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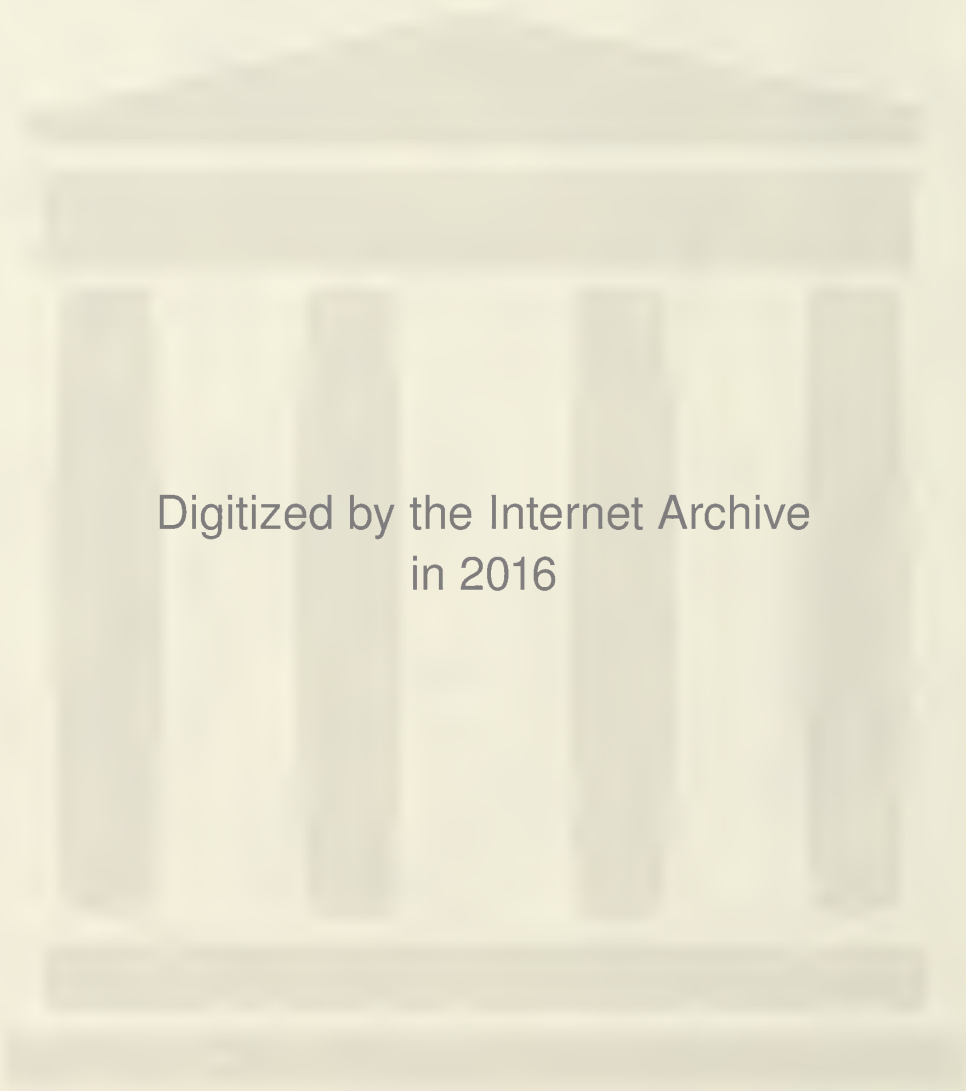
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Rhode Island
Medical Journal

Subject and Author Index
Volume 63, 1980

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Components of Change in Rhode Island's Physician Supply, 1974-1977 Donald C. Williams

Trauma and Breast Cancer, or the Anatomy of an Insurance Claim John S. Dziob, MD, FACS

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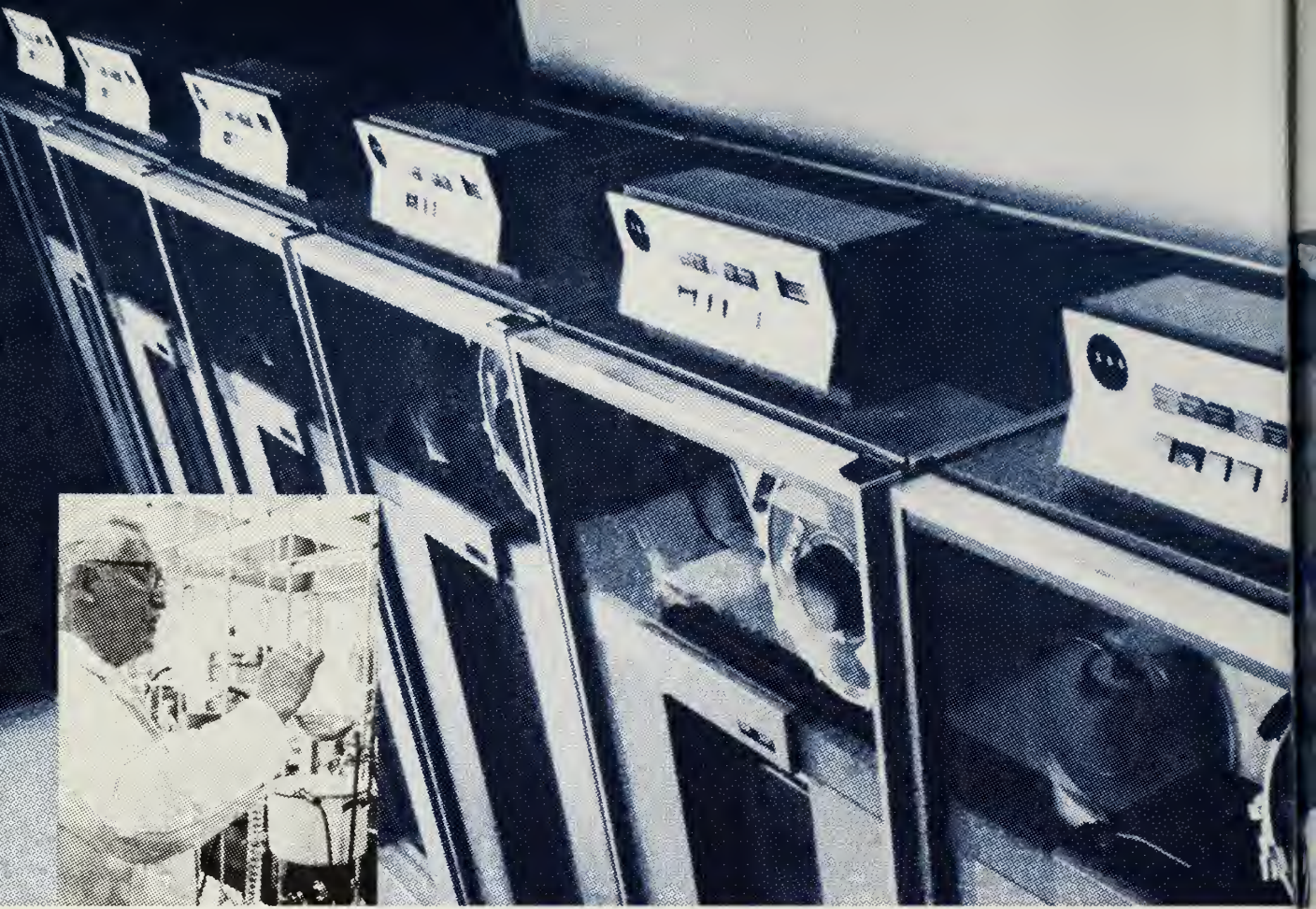

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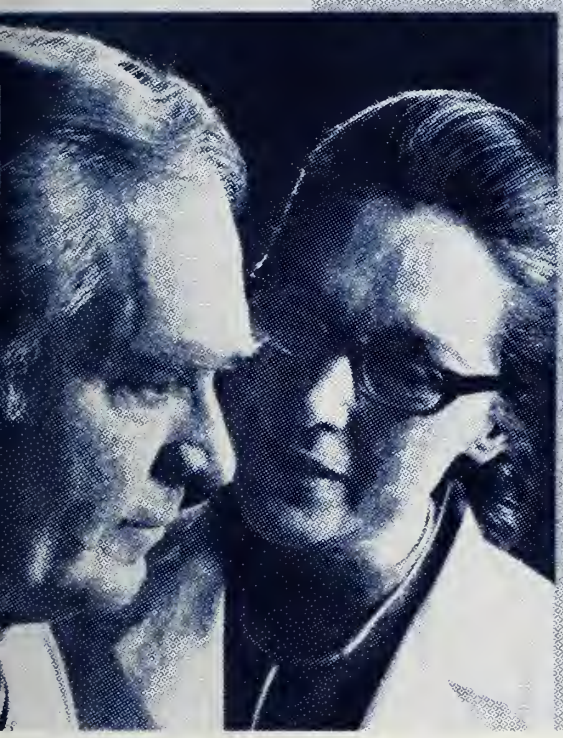

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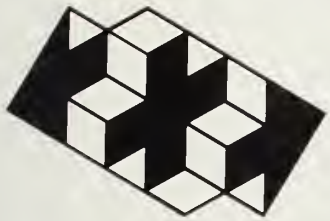

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9:15 AM:	Pre-operative Evaluation of Patients with Bronchogenic Carcinoma John Yashar, MD; James Yashar, MD; A. Weyman, MD; J. Burnard, MD
9:35 AM:	Hospice Care in Rhode Island Bruno Borenstein, MD
9:55 AM:	The Treatment of Carcinoma of the Rectum: Critical Mid-Segment Juan Medina, MD
10:15 AM:	Hereditary Anti-Thrombin III Deficiency: A Rhode Island Variety T. Myers, MD; J. Bishop, MD; S. Berry, MD; B. Kim, MD; M. Steiner, MD; M. Baldini, MD
10:35 AM:	REFRESHMENT BREAK
10:55 AM:	Pancreatic Pseudocysts: Current Concepts of Natural History E. Feller, MD; D. Kaufman, MD; H. Rakatansky, MD; P. Torgan
11:15 AM:	Experience with Liver Abscess in a Community Hospital Arthur Bonivart, MD
	SYMPOSIUM: SURGERY AND THE STROKE PATIENT
11:30 AM:	Non-Invasive Diagnosis of Cerebral Vascular Disease Frank Schaberg, MD
11:50 AM:	Surgical Correction of Extracranial Cerebral Vascular Disease Walter Cotter, MD; David Barry, MD; Paul Bernstein, MD
12:15 PM:	The Microvascular Surgical Approach to the Stroke Patient Michael Scott, MD, Associate Professor of Neurosurgery, Tufts-New England Medical Center, Boston, Massachusetts
12:45 PM:	Panel Discussion
1:00 PM:	LUNCH

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*Incidence 3% to 9%.

Incidence less than 1 in 100

Gastrointestinal: Upper GI ulcer with bleeding and/or perforation, hemorrhage, melena. **Central Nervous System:** Depression, insomnia. **Dermatologic:** Vesiculobullous eruptions, urticaria, erythema multiforme. **Cardiovascular:** Congestive heart failure in patients with marginal cardiac function, elevated blood pressure. **Special Senses:** Amblyopia (see PRECAUTIONS). **Hematologic:** Leukopenia, decreased hemoglobin and hematocrit.

Causal relationship unknown

Gastrointestinal: Hepatitis, jaundice, abnormal liver function. **Central Nervous System:** Paresthesias, hallucinations, dream abnormalities. **Dermatologic:** Alopecia, Stevens-Johnson syndrome. **Special Senses:** Conjunctivitis, diplopia, optic neuritis. **Hematologic:** Hemolytic anemia, thrombocytopenia, granulocytopenia, bleeding episodes. **Allergic:** Fever, serum sickness, lupus erythematosus syndrome. **Endocrine:** Gynecomastia, hypoglycemia. **Cardiovascular:** Arrhythmias. **Renal:** Decreased creatinine clearance, polyuria, azotemia.

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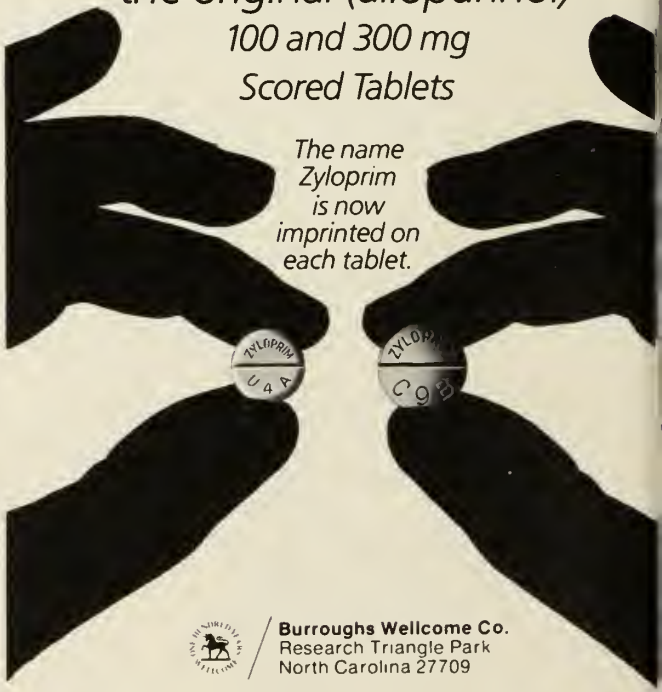

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ode Island Medical Society

January-February 1980

lewsletter

James R. Clarkin, Editor

Note to Readers

The *Rhode Island Medical Society Newsletter* is a monthly insert publication of the *Rhode Island Medical Journal*. It's aim is to provide news of medical and health affairs in our community. Your contributions and comments are welcomed.

Peter L. Mathieu, Jr., MD
Karen Challberg, MA

Report from the Mediation Committee

elvin D. Hoffman, MD

he Mediation Committee of the Rhode Island Medical ociety has received a number of complaints referable o problems relating to the transfer of medical records. he following is an excerpt from the *Judicial Council pinions and Reports* of the American Medical ssociation, copyright 1977:

The interest of the patient is paramount in the ractice of medicine, and everything that can easonably and lawfully be done to serve that interest ust be done by all physicians who have served or are erving the patient. When a colleague who is presently reating a patient requests records from another phyician who has formerly treated the patient, that former hysician should promptly make his records available o the attending physician.

No set rule can be laid down to cover the manner in hich the records are to be transmitted to the ttending physician. Under some conditions, a ersonal inspection of the records might suffice; under thers, an oral report of what is contained in the ecords would be of help; or in other circumstances, a ummary of the records might be made. In extreme ases, a physician might lend his complete record to he attending physician. The manner of making the eport—or the information contained therein—available to the succeeding physician is immaterial and will epend on the circumstances of each case. Certainly, owever, the attending physician should not demand or xpect more information from the former physician han is necessary to give the patient adequate care in he present illness.

It is assumed, of course, that proper authorization for he use of these records has been granted by the atient.

It is unethical for a physician, who formerly treated a patient, to refuse for any reason to make his records of that patient promptly available on request to another physician presently treating the patient.

Medical notes made by a physician in private practice are for his own use in treating a patient and belong to him. With the patient's consent, the record may be examined by an attorney, another physician engaged by the patient, or other party, but the patient has no legal right to its possession or ownership. The record is physically the personal property of the physician, although the patient (or his legal representative) has certain legal rights to the information contained in the record about the patient's diagnosis and treatment.

The record is a confidential document involving the physician-patient relationship and should not be communicated to a third party without the patient's prior written consent, unless it is required by law or is necessary to protect the welfare of the individual or the community.

Medical reports should not be withheld because of an unpaid bill for medical services. Simplified, routine forms can be prepared without charge, but a charge for more complex, complicated reports may be made in conformity with local custom.

As can be seen by the above, the Mediation Committee has adopted the following posture in regard to matters relating to transfer of patient records:

1) Patients should authorize (in writing) the transfer of records.

2) The former physician is obligated to provide the attending physician with the information requested and with sufficient documentation so that the attending physician can continue adequate care of the patient.

3) Ordinarily, there is no charge made either to the patient or the attending physician relative to the transfer of records. In the event, however, that detailed reports, letters or office notes are required, the physician is within his prerogative to charge a fee covering the cost of reproduction of these materials.

4) Transfer of records from a former physician to a new attending physician cannot be delayed because of outstanding bills to the former physician. The former physician, in addition, should not demand payment of outstanding accounts as a prerequisite to forwarding records.

The physician is obligated to make this transfer as above to a new attending physician on one occasion only. Should other physicians require reports or the patient, in turn, transfer once again to another physician, the previous physician is not required to send reports. Ordinarily, however, courtesy to a colleague may require such information to be sent. In

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is case, however, the physician may make a charge onsistent within his own office policy for such formation.

Medical records are the property of the physician. ne patient is, however, entitled to information ontained in that record. The patient may request this formation via his legal representative and with a gned authorization. In the event that such information requested, the attending physician may make a harge for this service. ■

SPARI Holds Annual Meeting

eter L. Mathieu, Jr., MD

The Association of Presidents of Hospital Staffs in hode Island, now called the Staff Physicians Associaon of Rhode Island, held its sixth annual meeting in ecember in the VIP House of The Memorial Hospital, awtucket, Rhode Island. This annual event, which tates among the 16 hospitals in the state, was hosted y David R. Hallmann, MD, president of the medical aff of The Memorial Hospital; Percy Hodgson, PhD, resident of the board of trustees of The Memorial ospital; and Francis R. Dietz, executive vice president The Memorial Hospital.

After cocktails and a superb dinner, President chard F. Judkins called the meeting to order. There as an excellent presentation by Barry Decker, MD, of rthur D. Little, Inc. concerning his evaluation of the roposed Rhode Island State Health Plan developed by e Statewide Health Coordinating Council. Arthur D. ttle, Inc. was hired by the Voluntary Committee of ealth Providers, which is made up of members of the hode Island Medical Society, the Hospital Associaon of Rhode Island, the Staff Physicians Association Rhode Island, and the Rhode Island Osteopathic hysicians Association. Dr. Decker discussed populaon projection, short-stay hospital beds, utilization rgets, required occupancy, bed needs, health manower, physician manpower, nursing manpower, ospital based specialist needs, primary care physician stribution, provider consortia, health service boards, inimal hospital size standards, hospital financing, penditure caps, and the statewide hospital developent fund issue.

Members in attendance included Raymond W. aggoner, Jr. and Hugo Taussig (Bradley Hospital); illiam Braden, III (Butler Hospital); Joan Abar ranston General Hospital); Loren R. Brown and H. erald Rock (Kent County Hospital); George T. Van Petten d Charles L. Hopper (Newport Hospital); Charles L. ll and Robert Kinder (Rhode Island Hospital); P. seph Pesare (Roger Williams Hospital); Peter L. athieu, Jr. and Erminio Cardi (St. Joseph's Hospital); chard F. Judkins (South County Hospital); Vincent A. Alessandro, Clinton Potter and Edward Cardillo omen & Infants Hospital); Faridoon Kahn and John Baxter (Woonsocket Hospital); Naeem Siddiqu ogarty Hospital). Representatives from The Miriam ospital and Westerly Hospital were excused. Guests the meeting were James R. Clarkin, Executive rector, Rhode Island Medical Society; Howard E. wton, Assistant Executive Director, Rhode Island Medical Society; Peter Holman, Vice President — Planning, Hospital Association of Rhode Island; Charles E. Millard, MD, Chairman, Subcommittee on SHCC, Rhode Island Medical Society; and Barry Decker, MD, Consultant, Arthur D. Little, Inc., Cambridge, Massachusetts.

New officers elected at this meeting are: David R. Hallmann, MD, President; John C. Baxter, MD, Vice President; Erminio Cardi, MD, Secretary-Treasurer. The Executive Committee will include the above officers and the following elected members: Joan Abar, William Harrahan, Richard Judkins, Peter L. Mathieu, Jr., P. Joseph Pesare, MDs.

Mrs. Donald (Virginia) Larkin, Executive Secretary of the Association, was applauded for her consistent hard work in making the organization effective; and Richard Judkins, MD, Outgoing President, received a vote of thanks for his three years' stewardship of the organization, during which time relationships of the physicians with third party carriers and the Rhode Island Medical Society were clarified and enhanced.

The Association, in addition to its annual meeting, holds three meetings a year. In its articles of organization it is described as existing for the purpose of unifying the action of organized hospital staffs in relationship to hospital patients with government third parties and consumers; and to serve in liaison relationship with the Rhode Island Medical Society in various areas. The impetus for the establishment of this Association came from the American Medical Associaton Council on Medical Service at the AMA House of Delegates annual convention meeting in June 1974. The next meeting of the Association will be held May 1980 at Fogarty Memorial Hospital, Woonsocket, Rhode Island. ■

Champus Increase . . .

An expansion of CAT Scan coverage for CHAMPUS beneficiaries will be implemented this year, which will authorize whole body scans and set other new guidelines for determining medical necessity for CAT Scan services.

When the expanded CAT Scan policy is implemented, it will be retroactively effective to October 1, 1978. ■

Internist Available

University-trained Internist seeking to associate in hospital-based or group practice of Internal Medicine in Rhode Island or Southeastern Massachusetts area. Available immediately. Call (302) 422-5454

Members Speaking Out on the SHP

"The basis for the state health plan should be to reduce illness," said **Dr. Charles L. Hill**, president of the Rhode Island Medical Soci "To reduce those of us who care for sick people is ridiculous."

Providence Sunday Journal, October 28, 1

Limiting the number of physicians who can practice in Rhode Island would be "a mistake," and closing 855 of the state's hospital b "could well be a major tragedy," according to **Dr. Stanley M. Aronson**, dean of medical affairs at the Brown University Progran Medicine.

Providence Sunday Journal, October 28, 1

Dr. Janis Gailitis, Newport Hospital's chief of medicine, said the prospective cut in bed space here would also mean a drastic cu services.

Newport Daily News, editorial, November 19, 1

Dr. Charles E. Millard: Doctors will not, and cannot in good conscience, tolerate this state of affairs, no matter what the price resistance. Our fellow citizens should realize that this battle is theirs as well. If this can be done to the physician today, tomorrow victim will be the plumber, carpenter and the mason, and all others in our society.

Providence Journal, letter, December 3, 1

Dr. Gerhard C. Meier, board member, satirized what it would be like at Newport Hospital if medical services are centralized upst "Gone will be most of what a patient can receive in this hospital now . . . Gone are the days of 1873, of dogsled transportation Providence. But coming are the days of helicopters landing on the top of Newport Hospital, transporting you to Providence."

Newport Daily News, December 13, 1

The Westerly Pawcatuck Council of Community Services supports efforts to improve and develop present services locally, and star behind Chief of Staff **Dr. Robert L. Lombardo's** thoughts as expressed in a recent *Sun* article that: "The means to achieve the objectives as spelled out in the (State Health) plan disregard the unique needs of individual hospitals and individual communities."

The Sun (Westerly, RI), letter, December 18, 1

Dr. Charles L. Hill, president of the Rhode Island Medical Society, scoffs at the notion (limiting of physicians): "There could be 50,(doctors here," he says, "but if their patients don't need care they'll sit and do nothing."

Medical World News, December 24, 1

As **Dr. Richard A. Carleton**, chairman of the 30-member SHCC which wrote the plan, observed, the report is "just a set recommendations" which will "lie fallow" unless the public wants them implemented. "No one has a gun at anyone's head. That's appropriate."

Providence Sunday Journal, editorial, December 30, 1

Dr. Charles E. Millard: "It would appear that we are being offered a pig in a poke . . ."

RIMS Newsletter, December 1

"I think you are in for a great surprise," **Dr. A. John Elliot** said. "Although you are our guests, you are by no means welcome. You ha walked into a community that is happy with its health care system. You walk in and say you are going to make it better. Who invi you?"

The Day (New London, Connecticut), January 3, 1

"I have pity for all of you (SHCC)," **Dr. Joan Abar** said, "because you were duped by the bureaucrats."

Providence Journal, January 9, 1

Dr. Richard Judkins: "It is not sufficient, in our view, to rebuke our concerns as unwarranted because the State Health System Plan v not have the force of law . . . This would seem to suggest that we professionals should not be concerned with the development of st health policy, and rather limit our efforts to activities in the political arena."

Providence Journal, editorial, January 12, 1

Dr. Peter L. Mathieu, Jr. asked why have not the health planners put a price tag on carrying out many of its "star trek, untested hea system concepts?"

The Evening Times (Pawtucket, RI), January 17, 1

"There is no means of monitoring the effect of the plan." **Dr. Paul Metcalf** said, "Suppose you are wrong?"

The Evening Times (Pawtucket, RI), January 18, 1

Dr. Charles Cox, chief anesthesiologist at Memorial, said the plan is the "beginning of socialized medicine".

The Evening Times (Pawtucket, RI), January 18, 1

Royal C. Hudson, Jr., a radiologist at Memorial, said the SHCC recommendation to put a limit on the number of radiologists in the st is based on poor data.

The Evening Times (Pawtucket, RI), January 18, 1

Dr. David Hallman, president of the Pawtucket Medical Association, said the plan "could mean health care rationing".

The Evening Times (Pawtucket, RI), January 18, 1

Legislative Review

Howard E. Lawton

H5477 (McKenna, Sherlock) — An Act Relating to Instruction in Abortion and Sterilization Procedures. Drs. J. Douglas Nisbet, Andrew S. Blazar spoke on this bill.

H5267 (Lamb, Mahoney, Tucker, Bove et al) — An Act Creating the Home Health Care Insurance Act. Drs. Steven J. Fortunato, James A. McGrath spoke on this bill.

Copies of all bills introduced in the present legislature 1980 as well as the 1979 legislature, are available in the office of the Rhode Island Medical Society by calling: 331-3207.

The first organizational meeting of the Public Laws Committee for the current legislature was held in De cember under the chairmanship of Dr. Peter L. Mathieu Jr.

A list of the Public Laws Committee follows: Drs. Reid S. Appleby, Jr., Peter D.T. Clarisse, John J. Coughlin, John J. Cunningham, Frank D'Alessandro, Richard P. D'Amico, Joseph J. Delfino, Frank P. Duffy, Donald P. Fitzpatrick, Stephen J. Fortunato, Henry B. Freye, Stanley W. Gale, David R. Hallmann, James K. Herstoff, William C. Howrie, Jr., Royal C. Hudson, Jr., Stephen J. Kamionek, Alban J. LeBlanc, A. Louis Mariorenzi, Peter L. Mathieu, Jr., James A. McGrath, Charles E. Millard, Joseph R. Peltier, Richard W. Perry, Charles P. Shoemaker, Hugo Taussig, Richard L. Testa, Paul T. Welch; Atty. Charles Butterfield.

Council Briefs

eeting January 14, 1980
harles L. Hill, MD, Presiding

Voted that the SHCC Subcommittee become a regur committee of the Society and that its membership clude at least two representatives from each district ciety.

Discussed the composition of the Council, and greed to elimination of the category of "Commisoners." Also discussed alternatives to provide more eaningful statewide representation on the Council. so discussed holding future Council meetings in the hode Island Medical Society Building, instead of the ppe Club.

• Discussed Society sponsorship of a "practice management workshop", employing local business, legal and other professionals for their expertise in selected areas of concern to new practitioners.

• Heard a report by Mr. John Schroeder of Johnson & Higgins, Inc. on the progress of a study to determine the feasibility of a physician-owned insurance company in Rhode Island. Initial results show interest in such a company.

• Recommended nominees to the Blue Shield Board of Directors: Paul E. Barber, MD; Richard R. Dyer, MD; Paul J. M. Healey, MD; Leonard S. Staudinger, MD.

• Approved reappointments to the Search Board of Directors: Paul B. Metcalf, MD; Stanley D. Simon, MD.

• Authorized the president to name a Subcommittee on Nominations to present a slate of nominees for office in 1980-1981.

edical Meetings

ort County Medical Society; regular meeting; end of February (date to be decided).
r County Medical Society; regular meeting; end of February (date to be decided).
National Leadership Conference; Downtown Marriott Hotel, Chicago; February 21-24.
dence Medical Association; Annual Meeting; Cranston Hilton; March 5, 6:30 pm.
e Island Medical Society; Council Meeting; RIMS Building; March 10, 6:00 pm.
e Island Orthopedic Society; regular meeting; University Club, Providence; March (date to be decided).
ucket Medical Association; regular meeting; March 13.
e Island Chapter, American Academy of Pediatrics; Annual Meeting; RIMS Auditorium; March 19.
England Hospital Assembly; Hynes Auditorium, Boston; March 25-27.
e Island Medical Society; House of Delegates Meeting; RIMS Auditorium; March 26, 2:00 pm.
Shield Corporation; Annual Meeting; 444 Westminster Street, Providence; March 26, 5:00 pm.
e Island Dermatological Society; regular meeting; The Memorial Hospital; March 27, 8:30 pm.
e Island Chapter, American Academy of Family Physicians; board meeting; April (date to be decided).
ington County Medical Society; business meeting; April 9.
gy Foundation; meeting to form a Rhode Island Chapter; 95 Pitman Street, Providence; April 15, 70 pm.
e Island District Branch, American Psychiatric Association; Annual Meeting; Aboretum Restaurant, st Providence; April 21.
e Island Chapter, American Academy of Family Physicians; Annual Meeting; Rhode Island Inn, rwick; May 3.
e Island Society of Nuclear Medicine; regular meeting; May (date to be decided).
e Island Society of Allergy; regular meeting; May (date to be decided).
e Island Medical Society; Annual Meeting; Cranston Hilton; May 14.
ucket Medical Association; Annual Meeting; May 15.
e Island Chapters, American College of Surgeons and American College of Physicians; joint meeting; ow Beach Hotel, Bermuda; May 17-21.
e Island Dermatological Society; regular meeting; The Memorial Hospital; May 24, 8:30 pm.
e Island Society of Internal Medicine; Annual Meeting; May 28 (tentative).
E: Exact dates and times of advance listings should be confirmed with the sponsoring organizations.

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lew Medical Approaches o Obesity

seph A. Chazen, MD

orbid obesity represents a serious medical problem nd is associated with decreased life expectancy, ypertension, respiratory insufficiency, fluid retention, ucose intolerance, abnormal lipids, and an increased cidence of coronary artery disease. Treatment with etary restriction has generally been unsuccessful for variety of reasons including patient's inability to mply and physician's inability to motivate patients to ffectively restrict caloric intake. In general, patients ave tried multiple programs for weight reduction and any have succeeded on a temporary basis, although invariably the lost weight is regained. It is because of the serious nature of morbid obesity that we have embarked on this vigorous medical program.

The Obesity & Risk Factor Program can be looked upon as being composed of three major phases. The initial phase is characterized by a supplemented fast. After patients have been referred to the program by their private physician, they are evaluated medically and, if found suitable, enter a regimen of supplemented fast. During this period, patients in general, eat nothing but the protein supplement Optifast (this material is composed of 40 grams of Casein along with sucrose, electrolytes and minerals), although for those who cannot tolerate a complete fast, controlled amounts of food are allowed.

This program has been studied in great detail in many patients by Dr. Victor Vertes at the Mt. Sinai Hospital in Cleveland, and found to be quite safe and associated with very few complications or significant metabolic abnormalities. During the initial period of supplemented fast, patients are given potassium supplements, if necessary, along with multivitamins. In addition, since the diet contains very little sodium, all diuretic and antihypertensive therapy is discontinued immediately. Also, glucose intolerance, which is frequently observed in many of these patients, may also be treated without medication, oral hypoglycemic agents are discontinued and insulin dosage is markedly reduced and usually discontinued within the first few weeks.

During the time of the supplemented fast, the patients are seen weekly by the physician, and their biochemical profile is monitored on a regular basis. During this time, they are also exposed to group behavior modification sessions, during which a major emphasis is placed on an understanding of the caloric content of food, and each patient is given an individualized program of exercise and activity.

During the supplemented fast, males tend to lose 3-5 pounds per week and females 2-4 pounds per week on the average. Initially, the weight reduction may be more profound depending on the degree of sodium retention which is present at the inception of the program. After the patient has lost enough weight to approach 20-30 pounds of his ideal body weight, food is reintroduced. Initially, 200-300 calories per day along with Optifast and then subsequently as much as 500-1000 calories per day. During this time, behavior modification sessions continue on a regular basis, but the patient is seen less frequently by the physician.

Initially, most patients have at least 40 pounds to lose so that food is not reintroduced until they have had several months of behavior modification. During this time, they have had multiple opportunities to be exposed to food and to be educated regarding the caloric content of food. The behavior modification program continues during this time and a more aggressive physical exercise program is undertaken at the same time.

After they have successfully accepted food reintroduction, the patients are seen less frequently, but still seen on a regular basis so that they may maintain contact with the program and return if weight increase begins to occur.

Our initial response has been gratifying, and we have confirmed the observations of Dr. Vertes that patients tolerate the supplemented fast quite well, that no significant biochemical or physiologic alterations are observed, that initial weight reduction is rather rapid and continuous thus motivating the patients to continue with the program, and that the food selection and reintroduction to eating is associated with continued weitht loss and adherence to the program.

In view of the long term risks of obesity, the associated medical conditions and the limited alternatives, this medical approach seems promising, and we feel that failure is not an option at the Obesity & Risk Factor Program.

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PRESIDENT'S PAGE

Our Role in the 1980s

A new decade provides a reason for philosophizing.

Never before in my professional life has the time been so critical for the health profession to create together a more sensitive and yet economical system. There are many who believe the onslaught of state control has been overwhelming and harmful, but lack the desire to try to challenge it. I believe this is wrong. The 1980s could be very important years for modifying the system to function more efficiently, and for meeting changing times with genuine innovation. We could provide the leadership our state so desperately needs to truly achieve "equal access to quality health care at a reasonable cost." We must impress upon our legislators the necessity to include us in health planning. We must constantly point out the failures in other systems as well as ours, to prevent the unfairness of government plans such as Medicare, and inequities such as occur in the Veterans health system.

To do this, we must rid ourselves of our own internal dissent and parochialism. We can rightfully be the proud and caring physicians we saw in the dreams of our formative years, but we must become statesmen as well

as physicians. We must not fear innovation. We must be secure in the propriety of our own actions, and speak out with courage born of sincerity.

This new decade shall see changes unknown to us now. Only by becoming informed philosophically and politically as well as medically can we constructively participate in those changes.

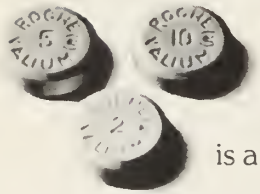
Charles L. Hill, MD
President

■

The first successful public demonstration of the use of ether in surgery took place on October 16, 1846, in Massachusetts General Hospital. According to his obituary, Doctor J.W.C. Ely was present on this historic occasion. Fifty years later, he received an invitation to assist at the semi-centennial celebration. Another prominent physician with Rhode Island family ties was James Fanning Noyes who "assisted in the . . . demonstration".

From Helen E. De Jong, Librarian Emeritus

A character all its own.



Valium (diazepam/Roche) is a benzodiazepine with a character all its own. Pharmacologically, it is a potent skeletal muscle relaxant and anticonvulsant (in adjunctive use), as well as an antianxiety agent. Pharmacokinetically, only Valium provides active *diazepam* as well as the active metabolites 3-hydroxydiazepam, desmethyldiazepam and oxazepam.

But the individual character of Valium is even more apparent clinically than pharmacokinetically. And far more significant. That's because of the patient response obtained with Valium. A response which brings a calmer frame of mind. A response which has a pronounced effect on the somatic symptoms of anxiety, particularly muscular tension. A response which helps the patient feel more like himself again because of the way Valium reduces the overwhelming symptoms of anxiety and psychic tension.

Another important aspect of the clinical character of Valium is safety. Though drowsiness, ataxia and fatigue are possible, these and more serious side effects are rarely a problem. Of course, as with all CNS-acting drugs, patients taking Valium should be cautioned against driving, operating dangerous machinery or the simultaneous ingestion of alcohol.

Unquestionably, many psychotherapeutic agents, including other benzodiazepines, have antianxiety effects. But one fact remains: you get a certain kind of patient response with Valium. It's a response you want. A response you know. A response you trust as part of your overall management of anxiety and psychic tension.

Valium® (IV)
diazepam/Roche

2-mg, 5-mg, 10-mg scored tablets

a prudent choice in psychic tension and anxiety

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states, somatic complaints which are concomitants of emotional factors, psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation, symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome; convulsive disorders (not for sole therapy)

The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma, may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed, drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported, should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Dosage: Individualize for maximum beneficial effect. *Adults*: Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d., adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients*: 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children*: 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

Supplied: Valium® (diazepam) Tablets, 2 mg, 5 mg and 10 mg—bottles of 100 and 500; Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Paks of 50, available singly and in trays of 10.

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DEAN'S MESSAGE

Alcoholism and the Medical Curriculum

The current issue of the *Rhode Island Medical Journal* contains an article on the diagnosis and management of the alcoholic patient, emphasizing the critical importance of early recognition and intervention. The author of the article, Dr. David Lewis, joined the Brown University Medical Faculty in 1976 as Associate Professor of Medicine and, concurrently, as the Donald G. Millar Distinguished Scholar in Alcoholism Studies. He has been active for over a decade in the field of addiction therapy, research and prevention. Dr. Lewis' appointment to our faculty was in recognition of the gravity of alcoholism as a profound societal and medical problem and reflects the commitment of this University to invest its educational resources in the understanding and treatment of both alcoholism and the parallel chemical dependencies. The classical teachings of alcoholism at most medical schools have been a paradox: largely ignored in terms of its origins, impact or ubiquity within the community but heavily emphasized as the etiology of various irreversible cerebral and hepatic diseases. It is difficult for the maturing medical student to think in terms of prevention or early intervention when the only examples employed are derelicts with advanced cirrhosis.

Dr. Lewis' activities have involved the University campus as well as the various hospitals of the greater Providence community. He has worked closely with a faculty Committee on Alcoholism and Drug Abuse with representation from the Sections of Medicine (Dr. J. DiMase), Family Medicine (Dr. S. Smith), Psychiatry (Dr. B. McCrady), Community Health (Dr. A. Wessen), Pharmacology (Dr. S. Cha), Obstetrics (Dr. J. Evrard), as well as Dwight Heath (Professor of Anthropology and an international authority on the cultural background of alcoholism) and Dr. Roswell Johnson, Director of the University Health Service and a person deeply involved in the management of various community efforts to contain alcoholism. The Committee and its individual members have had a profound effect upon this University.

In 1977-78 the role of alcoholism within the medical curriculum underwent significant revision as an outgrowth of the Committee's studies, which were aided by the work of a student committee which had independently prepared a comprehensive report of medical student views regarding this subject. Teaching on alcoholism currently permeates all four years of the medical school curriculum and includes first year seminars on alcoholism and drug abuse, numerous exercises on the physiologic and pharmacologic mechanisms of addiction, and is now incorporated into the required courses pertaining to nutrition, cardiology, neurology, psychiatry and gastroenterology. In addition, numerous clinical elective opportunities are provided for the fourth year medical student in the Providence community hospitals and in the Washingtonian Center in Boston.

At an undergraduate level the medical faculty now participates with Professor Heath in teaching an outstanding course on *Alcohol, Health and Culture.* During the past year, about 200 students registered for this elective.

Dr. Lewis and his colleagues have conducted numerous programs in continuing medical education for practicing physicians in the affiliated hospitals. In addition, clinical pharmacology conferences have been initiated at the Roger Williams General Hospital to provide participants with guidance regarding the use of psychoactive drugs in the therapy of addictions. An ambulatory clinic for the treatment of alcoholism has also been established at the Roger Williams General Hospital, staffed by a multidisciplinary group including social workers, counsellors, and physicians and nurses. Parallel research programs regarding the metabolic effects of alcohol are presently underway.

At the Butler Hospital, under the direction of Dr. Barbara McCrady, an inpatient alcoholism unit has been established, supported by a major grant from the National Institute on Alcoholism and Alcohol Abuse and designed to assess the effectiveness of various forms of therapy in families wherein one or more members are troubled by alcoholism.

At the Veterans Administration Medical Center in Providence, an active drug abuse treatment program is supervised by Dr. Ronald Paolino. Dr. Lewis and his associates have recently submitted a proposal to Washington for the establishment of a major inpatient alcoholism treatment service at this hospital.

The alcoholism committee has inaugurated, or encouraged the creation of, various inservice training programs for the employees of various hospitals within the community; it has also established consultative services in virtually all of the local hospitals and has sponsored various major conferences on this subject.

The diagnosis and treatment of alcoholism has become an essential component in the training of the resident physicians within The Memorial Hospital Family Medicine Residency Training Program under the direction of Dr. Louis Hochheiser.

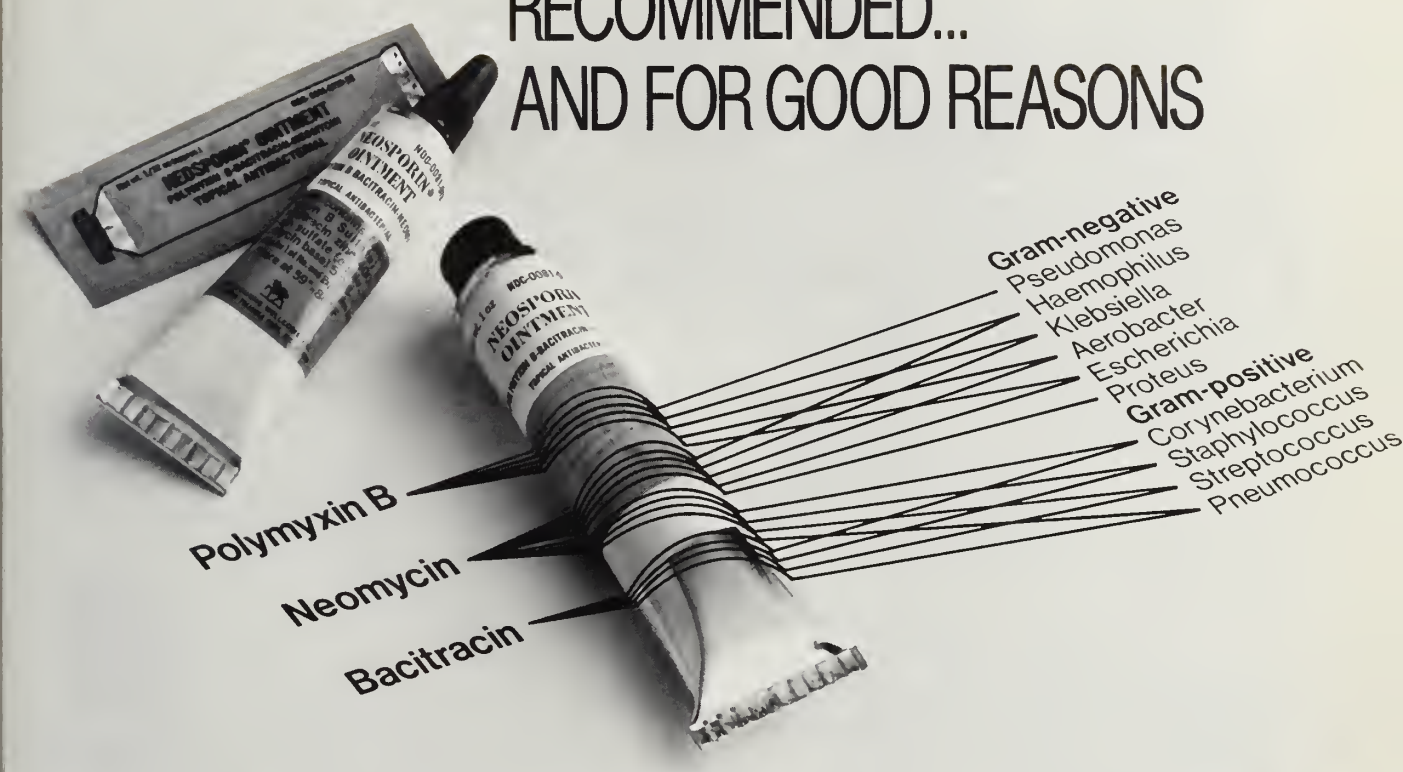
The Committee is also proposing a post-residency training fellowship to be sponsored by the University Sections of Medicine and Psychiatry. It will be the intent of this program to equip each participating Fellow with the clinical experience necessary to develop his/her skills as a competent addiction specialist who will be capable of providing the appropriate management for patients with alcoholism as well as individuals with other drug abuses. These Fellows will also be encouraged to become involved in clinical research programs pertaining to chemical dependencies.

The University campus has acknowledged the importance of alcoholism and has designated Professor Bruce Donovan as the administrator to supervise an educational and counselling service for undergraduate students (or faculty) who may be troubled by alcoholism.

Indifference will not cause alcoholism to disappear and innocence regarding alcoholism will not lessen its undeniable impact upon the physiologic, economic and moral health of our community. David Lewis and his many colleagues have provided us with a sound beginning to address these serious problems.

Stanley M. Aronson, MD
Dean of Medicine
Brown University

IT'S HIGHLY RECOMMENDED... AND FOR GOOD REASONS



- provides broad-spectrum, overlapping antibacterial effectiveness against common susceptible pathogens, including staph and strep
- helps prevent topical infections, and treats those that have already started
- it's good medicine for abrasions, lacerations, open wounds, primary pyodermas, secondarily infected dermatoses; and it's painless and cosmetically pleasing
- contains three antibiotics that are rarely used systemically
- you can recommend it in any of the three convenient package sizes: 1 oz tube, ½ oz tube, or the versatile, single-use foil packet

selected by NASA for the Apollo and Skylab missions

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polymyxin B-bacitracin-neomycin)

ch gram contains: Aerosporin® (Polymyxin B Sulfate) 00 units, bacitracin zinc 400 units, neomycin sulfate g (equivalent to 3.5 mg neomycin base); special white rolatum qs; in tubes of 1 oz and 1/2 oz and 1/32 oz pprox.) foil packets.

ARNING: Because of the potential hazard of nephro-icity and ototoxicity due to neomycin, care should be ercised when using this product in treating extensive rns, trophic ulceration and other extensive conditions ere absorption of neomycin is possible. In burns where re than 20 percent of the body surface is affected, pecially if the patient has impaired renal function or is eiving other aminoglycoside antibiotics concurrently, t more than one application a day is recommended.

When using neomycin-containing products to control secondary infection in the chronic dermatoses, it should be borne in mind that the skin is more liable to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching; it may be manifest simply as a failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.

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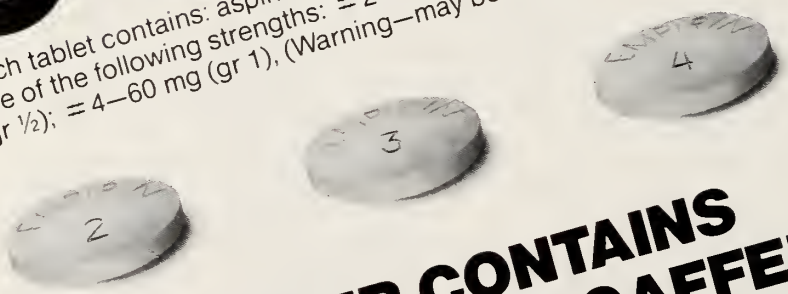

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EDITORIALS

Alcoholism Identified

The incredible magnitude of the problem of alcoholism as a public health menace is slowly emerging in the public and professional consciousness. Recognition of the reality of alcoholism in individual cases is sometimes difficult and long delayed, but is a necessary antecedent to effective management. How can one recognize that a regular, heavy drinker has crossed the line to alcoholism and addictive drinking. The American Medical Association in its Manual on Alcoholism points to some markers to help identify the alcoholic:

1. Increasing consumption of alcohol, with frequent, perhaps unintended, episodes of intoxication.
2. Drinking to handle problems or relieve symptoms.
3. Obvious preoccupation with alcohol and the frequent need to have a drink.
4. Surreptitious drinking or gulping of drinks.
5. Tendency toward making alibis and weak excuses for drinking.
6. Refusal to concede what is obviously excessive consumption and expressing annoyance when the subject is mentioned.
7. Frequent absenteeism from the job, especially following weekends and holidays.
8. Repeated changes in jobs, particularly if to successively lower levels, or employment in a capacity beneath ability, education and background.
9. Shabby appearance, poor hygiene, and behavior and social adjustment inconsistent with previous levels or expectations.
10. Persistent vague physical complaints without apparent cause, particularly insomnia, stomach upsets, headaches, loss of appetite.
11. Multiple contacts with the health care system with disorders that are alcohol caused or related.
12. Persistent marital and family problems, perhaps with multiple marriages.
13. History of arrests for drunkenness or drunken driving.

Health Maintenance

The federal government makes much of the potentialities of "health maintenance" as a means of reducing health care costs. Health maintenance organizations are subsidized, not only to rescue us from the wastefulness of a "cottage industry", but to economize by "keeping people well".

The government often speaks with forked tongue. The federal Medicare law apparently was based on a different philosophy. We shall list here a number of Medicare exclusions. The most egregious of these is the denial of reimbursement for "routine" physical examinations. While there might be some justifica-

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tion for such an exclusion in the young or middle aged, it certainly makes no sense for the typical Medicare beneficiary, who is aged 15 or older. Without going into the silly inconsistencies involved in each case, a listing of other exclusions is revealing. These include immunizations (influenza, pneumococcus); Pap smears; eye examinations for the purpose of prescribing, fitting, or changing eyeglasses; eyeglasses; care, treatment, fitting, removal, or replacement of teeth or structures supporting the teeth (including alveolectomy and torus removal in preparation for dentures); dentures; examinations for hearing aids; hearing aids; orthopedic shoes (often required for bunions and hammer toes so common in the elderly); and white canes for use by the blind.

The regulations are carefully drawn to make reimbursement for these services and appliances difficult and usually impossible. It may be possible to bypass the exclusion for routing physicals, because few persons beyond the age of 65 are without some complaint. Yet the applicable regulation reads: "Routine physical checkups include examinations performed without relationship to treatment or diagnosis for a specific illness, symptom, complaint, or injury."

With respect to eye examinations the regulation reads: "Where a beneficiary goes to his ophthalmologist for an eye examination with no specific complaint, the expenses for the examination would not be covered even though *as a result of such examination the doctor discovered a pathological condition.*"

And finally with respect to immunizations: "Vaccinations or inoculations are excluded as 'immunizations' unless they are directly related to the treatment of an injury or direct exposure to a disease or condition." Even "influenza inoculations for highly susceptible patients" are "specifically excluded by the law". This latter is particularly flagrant, since the Public Health Service regularly recommends flu shots for elderly persons.

We should not be hasty, however, in attributing these foolish inconsistencies to the bureaucracy of HHS (formerly HEW). The regulations involved are in general an accurate reflection of the statutory provisions — they are written into the law. There is, however, virtually a conspiracy of silence about them because payment would be expensive. But let us fill these gaps before going into new ventures.

The next time your solicitous congressman or senator dilates upon the virtues of "health maintenance," remind him of these stupid exclusions from Medicare coverage.

A Cover History

The *Rhode Island Medical Journal* has been around for sixty-three years, since it was born of a marriage of the old *Transactions of the Rhode Island Medical Society* and the short-lived *Providence Medical Journal.* The count of total papers and contributors for these years now numbers in the thousands. There have been also several cover formats, and a new one this month makes it an appropriate time for looking backwards.

For the years 1917-1938, excluding 1919 when in the wake of World War I it did not publish, the *Rhode Island Medical Journal* had a cover which shared table of contents space with one or another advertiser (Fig 1-1). Armour and Co, Chicago advertised a variety of medical instruments and remedies during those years such as strong, absorbent uncontaminated ligatures from selected lamb's gut: "Just What a Ligature Should Be"; or Pituitary Liquid: "The product is of standard strength. The package is dated. The doctor knows. He doesn't trust to luck." Aylesworth Travel Service, then at 36 Weybosset Street, had a place on the frontispiece for several years suggesting most frequently a cruise in the South Seas as "Rx for jaded land-weary nerves". Hood Milk Co; Mead Johnson & Co, Evansville, Indiana, often self-described as "Pioneers in Vitamin Research";

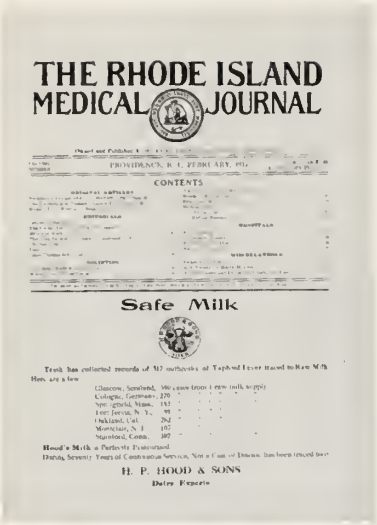

Figure 1-1 Februarv. 1917

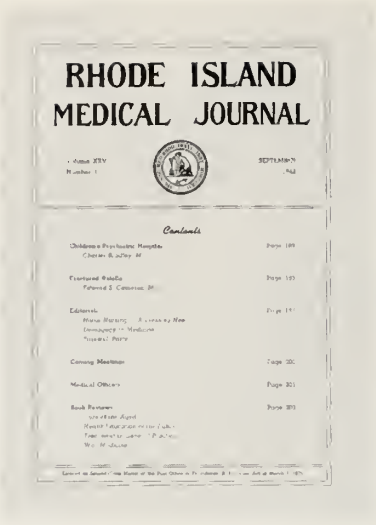

Figure 1-2 September, 1942

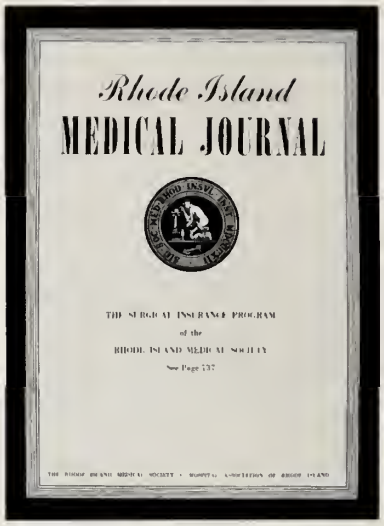

Figure 1-3 October, 1947

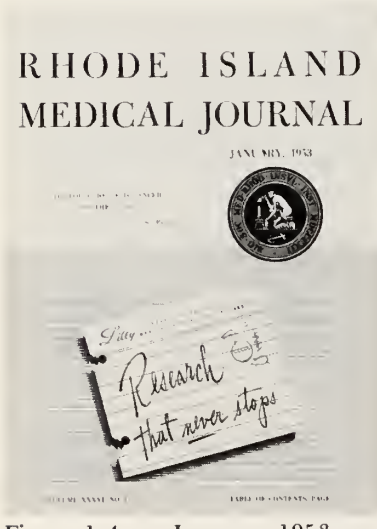

Figure 1-4 January, 1953

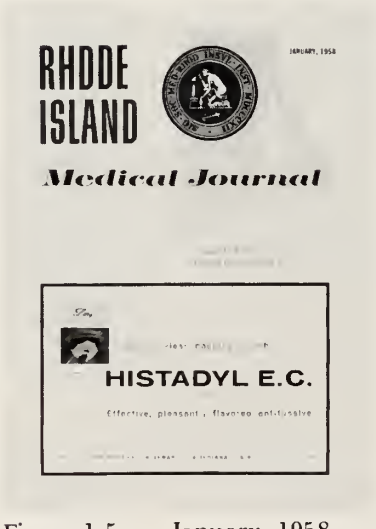

Figure 1-5 January, 1958

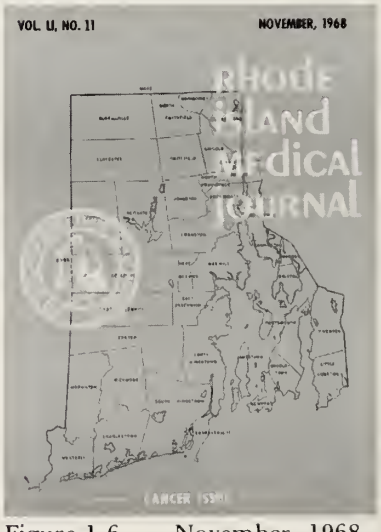

Figure 1-6 November, 1968

Figure 1-7 June, 1970

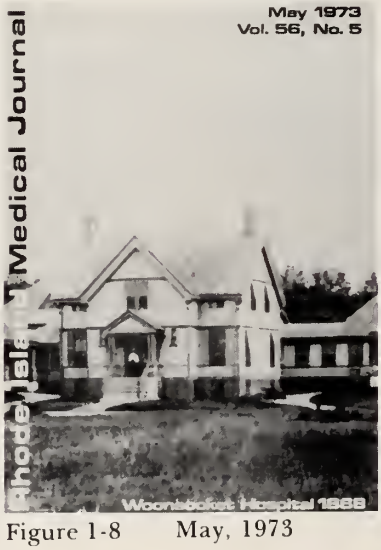

Figure 1-8 May, 1973

Figure 1-9 September, 1974

and the George L. Claflin Co, then at 150-160 Dorrance Street, Providence, likewise took the spot for a year or more at a time. The habit of sharing table of contents space with commercial space was one which would return in 1952.

For the twelve years from 1939-1951 the *Journal* presented itself in an increasingly "aesthetic" mode. The plain black on white table of contents cover from 1939-1941 was fancied in 1942-1943 by the addition of red borders (Fig 1-2). Then, 1944 saw the table of contents moved inside and below a new logotype the Rhode Island Medical Society seal became the central focus, which it would remain through 1951. The only variation was a different colored border every month from 1946-1951, during which years the cover had a *Time*-like appearance (Fig 1-3).

Eli Lilly Co is one of the most regular advertisers in the *Rhode Island Medical Journal* today. During recent past years the company has often purchased the standard position "facing first editorial". For the sixteen years from 1952-1967 for month after month it advertised a succession of drugs on the cover's bottom half, and also supplied two different formats including logotypes (Figs 1-4, 1-5). With Lilly there was a return to standard red and tones of black on white. 'Trinsicon' (1955); Histadyl EC® "for Nagging Cough" (1958); Ilosone® (1962); and Amytal® (1965) were among the products the company marketed most intensively.

After so many issues of the above, 1968-1969 provided a plain but bright change. A new format including logotype and seal, superimposed on an outline map of Rhode Island, was presented on a variety of brightly colored backgrounds (Fig 1-6). The contents were also lively featuring papers such as "The Imperatives of Choice", which dealt with the problem of inflation, and "The Changing Complexion of Medical Care", which was subtitled "The Growth of Specialization Is Inevitable, But Family Practice Must Be Preserved". Perhaps it was by popular demand that this time saw a growing variety of contributions on medically related socio-economic subjects. It is interesting to note now, twelve years later, a passage from "The Future of Health Insurance — A View of 1985" published in 1968:

"The potpourri of health benefits in 1985 will unquestionably include a government system for the entire population. While there is a distinct possibility that such a plan would be completely administered by the government, present indications are that an 'administrative buffer' between government and the providers of care will be retained."

The decade of the 1970s, like the 1980s, was heralded by a major innovation of design for the *Journal*. The turning point between decades is an opportunity for fresh changes and beginnings and visions. This spirit was symbolized in January 1970 by the first of a series of cover designs by "Graphic Consultant" George Patton, Jr, who was then affiliated with the Rhode Island School of Design. Patton gave the *Journal* each month for five years a new face in the form of drawings, designs, photographs, often linked thematically with the issue's contents. He was also responsible for the 1970s logotypes, of which there were three (Figs 1-7, 1-8, 1-9).

Because of cost constraints, the latter years of the 1970s did not continue as imaginatively as they had begun. In 1975 the Rhode Island Medical Society seal on the center cover became the standard differentiated from month to month only by color and by contents announcements. This was a familiar look for five years through 1979 (Fig 2).

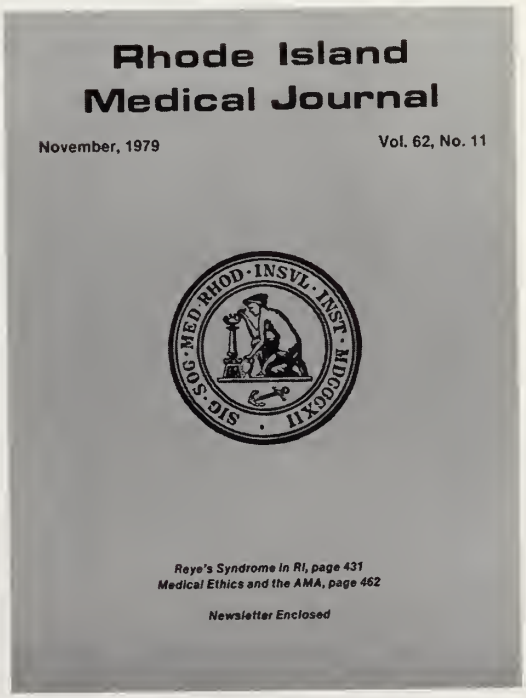
Rhode Island
Medical Journal
November, 1979
Vol. 62, No. 11
SIG. SOC. MED. RHOD. INSVL. INST. MEDICAE
Reye's Syndrome in RI, page 431
Medical Ethics and the AMA, page 462
Newsletter Enclosed

Figure 2

The new look for the 1980s (*see* cover) was designed by Mary Ann Frye, Instructor, Department of Graphic Design, Rhode Island

School of Design. Cover format, including logotype, are coordinated with modifications inside the magazine as well. The whole has been arranged for practicality and flexibility. The center portion of the cover page is a space adaptable to a variety of inclusions such as photographs and drawings. The summarized cover table of contents, which reinstitutes a practice of some of the *Journal's* earliest years, is for the convenience of readers. The encouragement and financial support of the Officers, the Council, and the House of Delegates of the Society prompted these and other improvements and is appreciated.

We shall endeavor during the new decade to continue to improve the quality of the *Journal* and increasingly to provide for our readers a discussion of the problems and pressures in the socioeconomic field. There will be growing need for this function in the years ahead as the turbulence in medicine and health care increases. While the 1980s undoubtedly will provide a succession of startling medical miracles, yet cost-effectiveness and cost control, as expenditures continue to rise, will most certainly be concerns.

Sincere wishes to our readers for a happy, healthy, and prosperous New Decade.

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"ELEGANT DINING"
MONDAY THROUGH FRIDAY
LUNCHEON: 11:30 TILL 3 P.M.
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- Convenient bedtime dosage.
- Works in the morning when she needs it most.

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AVAILABLE ONLY ON PRESCRIPTION

Brief Summary

INDICATION
Nausea and vomiting of pregnancy.

PRECAUTIONS
Because of potential drowsiness, Bendectin should be prescribed with caution for patients who must drive automobiles or operate machinery.
Studies in rats and rabbits have revealed no suggestion of drug-induced fetal abnormalities at doses of Bendectin up to 90 times the maximum human dose. In addition, several epidemiologic studies in women who received Bendectin during pregnancy have shown that the incidence of birth defects in their offspring is no higher than in women not taking the drug during pregnancy. Nevertheless, like all drugs considered for use during pregnancy, particularly during the first trimester, Bendectin should be used only when clearly needed.

ADVERSE REACTIONS
The adverse reactions that may occur are those of the individual ingredients. Doxylamine succinate may cause drowsiness, vertigo, nervousness, epigastric pain, headache, palpitation, diarrhea, disorientation, or irritability.
Pyridoxine hydrochloride is a vitamin that is generally recognized as having no adverse effects.

DOSAGE AND ADMINISTRATION
2 Bendectin tablets at bedtime. In severe cases or when nausea occurs during the day: 1 additional Bendectin tablet in the morning and another in midafternoon.

Product Information as of January, 1978

References:
1. Meyer, C.: American Folk Medicine. Scarborough, New York, Plum Books — New American Library, 1975, p. 208.
2. Data on file, MERRELL-NATIONAL LABORATORIES
Division of Richardson-Merrell Inc.
Cincinnati, Ohio 45215

Merrell

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1830: A decoction of columbo root and peppermint 3 or 4 times a day should be taken for the sickness to which pregnant females are commonly subject.[1]
TODAY: Clinical studies show statistically proven efficacy for morning sickness of pregnancy with delayed-release Bendectin tablets.[2]
In morning sickness confidence begins with
Bendectin®
Each tablet contains doxylamine succinate 10 mg., pyridoxine hydrochloride 10 mg.
trusted alternative to nausea and vomiting of pregnancy
For prescribing information see opposite page.

V-Cillin K®

penicillin V potassium

is the most widely prescribed brand of oral penicillin

Tablets
125, 250, and 500 mg*
Oral Solution
125 and 250 mg*/5 ml

V-Cillin K®
penicillin V potassium

Description: V-Cillin K is the potassium salt of penicillin V. This chemically improved form combines acid stability with immediate solubility and rapid absorption.

Indications: For the treatment of mild to moderately severe pneumococcal respiratory tract infections and mild staphylococcal skin and soft-tissue infections that are sensitive to penicillin G. See the package literature for other indications.

Contraindication: Previous hypersensitivity to penicillin.

Warnings: Serious, occasionally fatal, anaphylactoid reactions have been reported. Some patients with penicillin hypersensitivity have had severe reactions to a cephalosporin; inquire about penicillin, cephalosporin, or other allergies before treatment. If an allergic reaction occurs, discontinue the drug and treat with the usual agents (e.g., epinephrine or other pressor amines, antihistamines, or corticosteroids).

Precautions: Use with caution in individuals with histories of significant allergies and/or asthma. Do not rely on oral administration in patients with severe illness, nausea, vomiting, gastric dilatation, cardiospasm, or intestinal hypermotility. Occasional patients will not absorb therapeutic amounts given orally. In streptococcal infections, treat until the organism is eliminated (minimum of ten days). With prolonged use, nonsusceptible organisms, including fungi, may overgrow; treat superinfection appropriately.

Adverse Reactions: Hypersensitivity, including fatal anaphylaxis. Nausea, vomiting, epigastric distress, diarrhea, and black, hairy tongue. Skin eruptions, urticaria, reactions resembling serum sickness (including chills, edema, arthralgia, prostration), laryngeal edema, fever, and eosinophilia. Infrequent hemolytic anemia, leukopenia, thrombocytopenia, neuropathy, and nephropathy, usually with high doses of parenteral penicillin. (102175)

***Equivalent to penicillin V.**

Additional information available to the profession on request.

Lilly

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Indianapolis, Indiana 46206

900416

LETTERS

Medical Knowledge Self-Assessment Program V

To the Editor:

Newport, Rhode Island will be the site of a five-day course for internists participating in Medical Knowledge Self-Assessment Program V (MKSAP V) in mid June, 1980. The MKSAP V program was initiated by the American College of Physicians thirteen years ago with the purpose of providing its members with an opportunity to improve their medical knowledge in all fields of internal medicine in a voluntary manner. Over the years, the program has changed in structure and content to include all ten subspecialties in internal medicine as well as dermatology and neurology. In previous years, a single syllabus covered the entire internal medicine area and was followed by a voluntary home examination where scores were returned to the applicant in a strictly confidential manner. Confidentiality continues to be a part of the program, but the syllabus has greatly expanded and this year has been divided in three parts with each syllabus covering information on four subspecialty areas. Every three months, a section of the syllabus is mailed to the subscriber along with related multiple choice questions, critiques of the answers to the previous section, and score reports for those participants electing computer scoring.

MKSAP V will include eleven Patient Management Problems. Although the rapid expansion in new technology is included in these problems, the authors have maintained that cost containment is a relevant issue and presumably will be incorporated into these problems.

The postgraduate courses vary from twenty-two two-day courses throughout the country and Canada for each of the three sections of the syllabus to nineteen four and five-day courses, such as the one in Newport, which will cover the entire syllabus and each of the twelve areas of internal medicine.

Summer in Newport in 1980 will be vibrant. The trials for the America Cup Races are to begin in mid June attracting worldwide attention. In addition to an exciting time in a lovely city, the combined clinical medical faculties of Brown, Yale, and the University of Connecticut will provide a strong postgraduate course in preparation for recertification in internal medicine. We hope those of you interested will participate. We can guarantee that all who attend will have a rewarding experience.

The MKSAP V course will be held at the Sheraton Islander Inn, Goat Island, Newport, Rhode Island from June 16, 1980 to June 20, 1980. For further information contact the American College of Physicians, 4200 Pine Street, Philadelphia, Pennsylvania 19104 for further information.

Joseph D. DiMase, MD, FACP
ACP Governor for Rhode Island
Director MKSAP Course,
June 16-20, 1980, Newport, RI

From the Library Storeroom

To the Editor:

From the time William C. Bowen was elected Librarian and Cabinet Keeper (1812), through the terms of office of Librarians of the Southern and Northern Districts, and on to the present, one of the duties of the incumbent (s) has been to take care of the items given to the Society's "Museum." Over the years, the collection has grown. The pathological specimens exhibited at meetings have

perished, but many of the instruments, pictures, manuscripts, and other artifacts have endured and more are added each year. This is not a "dead" collection as items have been borrowed, displayed, and studied.

During the Centennial Celebration of the Providence Medical Association in 1948 and the Rhode Island Medical Society's Sesquicentennial Health Exposition in 1962, instruments were exhibited in various downtown windows for the delectation of the general public. The Smithsonian Institution borrowed three electrotherapeutic machines for the exhibit "Triumph Over Disability." The Warwick Museum uses us as a source for illustrations of local medical history. And every now and then a student arrives with notebook and camera in search of material for a term paper.

We haven't enough space to show our many microscopes, doctors' bags, surgical kits, forceps, stethoscopes, and other items, so most of them are boxed, labeled, and stored away to be brought out on demand. Some of the objects that are unique and that have excited particular interest are on view, however, in a case in our Reading Room: —

From the days when venesection was routine, we have inherited three blood-letting instruments. The donor of the single lancet is unknown, but the set of two beautifully engraved lancets with one dated 1775 and initialled I A G M, was given to the Society in 1909 by Doctor William J. Burge. This case was dug up in Brooklyn, NY, and acquired by Doctor Burge when he was in practice there. He also gave us the obstetrical forceps fashioned for his grandfather (Charter Member William G. Shaw) by the village blacksmith, a pewter bedpan, and a lead nipple shield. Our ancestors were hardy folk!

We have been told that our set of Perkins' Tractors is unusual, as pairs are seldom found. The history of this gift is described in a letter to Doctor Hersey which is framed with the tractors. Information about this universal remedy, guaranteed to cure all ailments, may be found in some pamphlets in our Rare Book Collection.

Among other objects on view are an apothecary scale, a wooden stethoscope, dental tools, a US Army Surgical Case, and pocket kits. There is a wooden box fitted with pretty aquamarine colored bottles that belonged to a Doctor Buckland. The apothecary bottle and the vaseline-glass tray for mixing ointments were given to the Library by Doctor Goldowsky.

Items from our Centennial Year occupy a shelf. These are photos of the exterior and interior of the building, taken in 1912, and the trowel which was used to lay the cornerstone in 1911.

We've kept a careful accounting of gifts in recent years, but the source of earlier acquisitions is often unknown. I've been taking advantage of the unbearably humid northern Florida summer afternoons to work indoors, searching the records of the Society for the names of donors. I've struck pay dirt several times and am sure more answers will be found as I travel on in this fascinating journey through time.

Mrs. Helen DeJong
Librarian Emerita
Honorary Member
Rhode Island Medical Society

Lithium in Depressed Chronic Alcoholics

To the Editor:

While doing a literature review on the efficacy of lithium carbonate treatment of alcoholism, I came across an excellent paper by the late Peter P. Reilly, MD (*RIMedJ* 61(2):86-91, Feb 78). This article features an important and neglected area of medicine, the treatment of chronic alcoholism. Doctor Reilly's use of lithium is a welcome, innovative approach to a chronic, disabling, and even fatal condition. Since approximately one-third to one-half of all hospital admissions are alcohol-related, attention to this problem is well-warranted.

At the University of Louisville Medical Center, we also employ lithium in the treatment of alcoholism. Our treatment of alcoholic populations with lithium meets with some improvements in many cases, and great success in a few.

I should like to offer a few editorial comments regarding lithium excretion and about psychoactive drugs other than lithium whose serum levels are monitored in the blood. Early in the paper, Doctor Reilly discussed lithium itself, and mentioned a competition between sodium and lithium in the distal convoluted tubules of the kidney. It is my understanding, actually, that in the proximal tubule, lithium and sodium are competitive; but the *proximal* tubule is the major site of lithium handling.[1,2] Lithium resorption in the distal collecting system of the nephron is probably not significant.[1,2] While it is agreed that it is good to have normal renal function when using lithium, the absence of good renal function is not an *absolute* lithium contraindication. Lithium can safely be administered to patients with some degree of renal dysfunction.[3,4] There is literature describing the use of lithium in the impaired renal patient, and of course this treatment must always be done with special caution and only with close monitoring. These factors are complicated by recent reports of lithium-induced renal injury,[5] but *any* treatment must be balanced against potential risk. I believe that it is important not to deny patients a chance at improvement by too restrictive use of chemotherapeutic agents. Frank Ayd is a standard-bearer regarding this principle generally, and also specifically in regard to lithium and kidney function.[6]

In the same paragraph of Doctor Reilly's paper there is mention of "detoxification" of lithium in the liver of more aged patients. Lithium, a simple water-soluble cationic salt, is subject to renal excretion as the primary route of elimination rather than by classical metabolism in the liver.[1,2] Hepatic detoxification of drugs characterizes organic substances, and indeed that process is slower in most geriatric persons but unrelated to lithium. The kidneys excrete virtually all the lithium that is introduced to the body, with small lithium loss in the feces, perspiration, tears, and sputum, and semen.[1,7] Elderly people do in fact excrete lithium more slowly, but this has to do with renal rather than hepatic mechanisms.

Keeping the serum level below 2 mEg/1 is mentioned in the article; most clinicians would agree with that, but actually would keep the serum level rather close to 1 mEg/1 and well below 2 mEg/1. There are some differences of opinion, but most physicians use 0.7 - 1.2 mEg/1 as an average range for serum lithium levels.

Doctor Reilly in his paper indicated that lithium is the only serum level monitored psychiatric drug. In recent years, however, there has been a great deal of literature and excitement, mostly in the research community concerning the monitoring of drug efficacy and side-effect potential of many psychatric pharmaceuticals.[8-10] These blood levels are available for major tranquilizers (ie antipsychotic medications or neuroleptics) such as the phenothiazines, and butyrophenones; but more importantly, for the tricyclic antidepressants, such as imipramine* and amitriptyline**[8-12] Major tranquilizer blood levels are not in very wide use clinically. Tricyclic antidepressant blood levels, however, are now both available and increasingly important in the management of patients with depression. There are important relationships between plasma levels of tricyclic antidepressants and clinical response. Tricyclic antidepressant blood levels are available in many medical centers and "mail-in" laboratories. Serum level determinations of tricyclic antidepressants are valuable in the presence of apparent tricyclic unresponsivity, in determining dose-response curves, in detecting noncompliance, and when closely monitoring particularly important side-effects such as in patients with cardiac conduction-defect.

I very strongly endorse the major message in Doctor Reilly's paper that every depressed chronic alcoholic should have a trial of lithium.

Steven Lippmann, MD
Assistant Professor
Department of Psychiatry
and Behavioral Sciences
University of Louisville

References

[1]Gershon S, Shopsin B (eds): Lithium: Its Role in Psychiatric Research and Treatment. New York, Plenum Press, 1973
[2]Singer I, Rotenberg D: Mechanisms of lithium action. N Engl J Med 289:254-260, 2 Aug 73
[3]McKnelley WV Jr, Tupon JP, Dunn M: Lithium in hazardous circumstances with one case of lithium toxicity. Compr Psychiat 22:279-286, May 70

*imipramine, Brand Names: Imavate®, Janimine®, Presamine®, Tofranil®, SK-Pramine®
**amitriptyline, Brand Names: Elavil®, Endep®

[4]Himmelhoch JM, Poust RI, Mallinger AG, et al: Adjustment of lithium dose during lithium-chlorothiazide therapy. Clin Pharmacol Ther 22:225-227, Aug 77
[5]Hestbech J, Hansen HE, Amdisen A, Olsen S: Chronic renal lesions following long-term treatment with lithium. Kidney Int 12:205-213, Sep 77
[6]Ayd FJ Jr: International Drug Therapy Newsletter 13(5), May 78
[7]Davis JM, Fann WE: Lithium. Annu Rev Pharmacol 11:285-302, 1971
[8]Ayd FJ Jr: International Drug Therapy Newsletter 13(9), Nov 78
[9]Hollister E: Drug therapy: Tricyclic antidepressants, part I. N Engl J Med 299:1106-1109, 16 Nov 78
[10]Biggs T: Clinical pharmacology and toxicology of antidepressants. Hosp Pract 13:79-84, Feb 78
[11]Ziegler VE, Co BT, Taylor JR, et al: Amitriptyline plasma levels and therapeutic response. Clin Pharmacol Ther 19:795-801, Jun 76
[12]Glassman AH, Perel JM, Shostak M, et al: Clinical implications of imipramine plasma levels for depressive illness. Arch Gen Psychiatry 34:197-204, Feb 77

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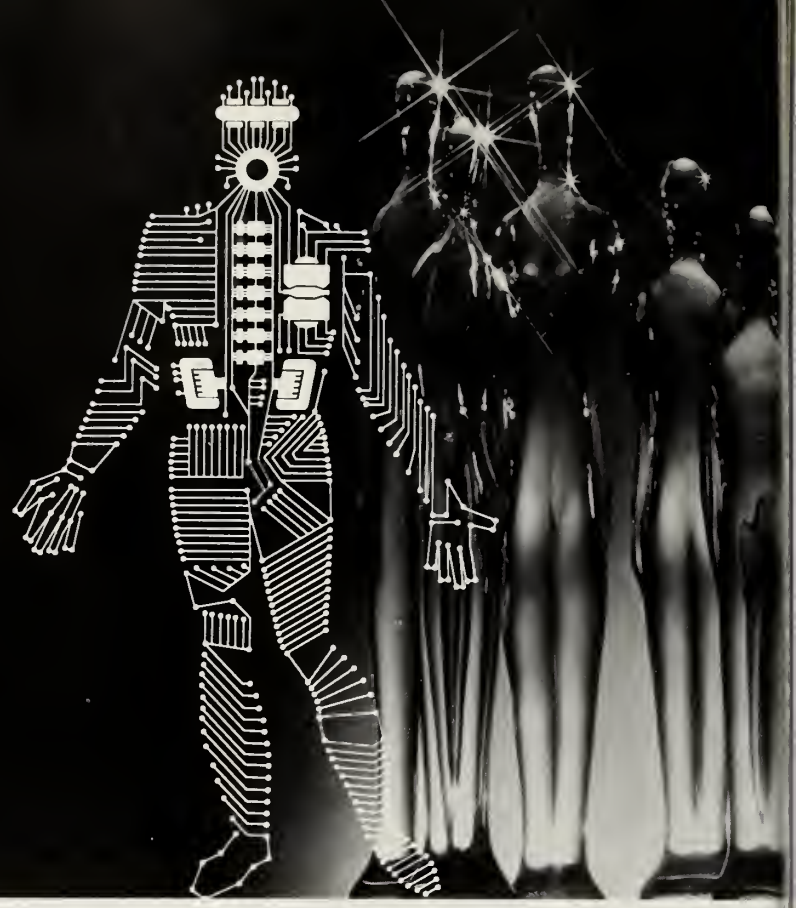

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Usage in Pregnancy: In view of embryotoxic findings in animals, and since information on possible adverse effects in pregnant women is limited to uncontrolled clinical data, the drug is not recommended in women who are or may become pregnant unless the potential benefits outweigh the potential risk to mother and fetus.
Usage in Children: No clinical experience is available with the use of Catapres (clonidine hydrochloride) in children.

Precautions: When discontinuing Catapres (clonidine hydrochloride), reduce the dose gradually over 2 to 4 days to avoid a possible rapid rise in blood pressure and associated subjective symptoms such as nervousness, agitation, and headache. Patients should be instructed not to discontinue therapy without consulting their physician. Rare instances of hypertensive encephalopathy and death have been recorded after cessation of clonidine hydrochloride therapy. A causal relationship has not been established in these cases. It has been demonstrated that an excessive rise in blood pressure, should it occur, can be reversed by resumption of clonidine hydrochloride therapy or by intravenous phentolamine. Patients who engage in potentially hazardous activities, such as operating machinery or driving, should be advised of the sedative effect. This drug may enhance the CNS-depressive effects of alcohol, barbiturates and other sedatives. Like any other agent lowering blood pressure, clonidine hydrochloride should be used with caution in patients with severe coronary insufficiency, recent myocardial infarction, cerebrovascular disease or chronic renal failure.

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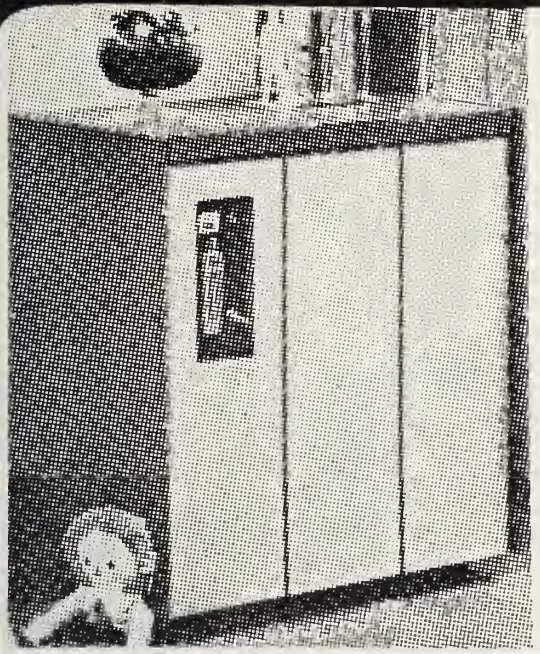

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Diagnosis and Management of the Alcoholic Patient

The Physician Has Opportunities For Early Intervention Which Can Improve The Prognosis Of A Major Health Problem

David C. Lewis, MD

The misuse of alcohol is the leading drug problem in this country, affecting 5 to 10 per cent of all drinkers. Alcohol is a physically addictive drug. As tolerance develops, so do unpleasant withdrawal symptoms when the person stops drinking; these symptoms include nervousness, sweating, insomnia, and the "shakes". Because the discomforts of withdrawal can be erased by more alcohol, excessive drinkers are strongly motivated to continue drinking—a vicious circle that compounds the physical, emotional, and social damage. Some people gradually lose control over drinking, and the illness of alcoholism takes over. For those with untreated alcoholism, normal life expectancy is reduced by twelve to fifteen years. The disease causes 95 per cent of cases of cirrhosis of the liver, the sixth major cause of death in the United States.

The individual personality characteristics of serious problem drinkers vary considerably, although studies indicate some relationship between alcoholism and heredity or early family life. Some people drink heavily because of psychological problems; others, because heavy drinking is the norm in their social or cultural group. Many who drink to excess or lose control of their drinking are concerned about it, and they suffer embarassment, guilt, the loss or diminution of respect from family and friends, and fears about jeopardizing lifelong goals.

People with alcoholism are found in all walks of life, not just on skid row. Most alcoholic patients who visit the doctor's office hold jobs or are employable and have active family ties. All of these factors contribute to a favorable prognosis.

With alcoholism, as with many other diseases, the earlier the diagnosis is made and intervention begins, the better the prognosis for recovery. People do not have to "hit bottom" before they can accept help. The primary care physician can detect alcoholism and initiate treatment while the chances for rehabilitation are still good. Yet many physicians are reluctant even to discuss the subject with suspected problem drinkers, either because they lack the time, temperament, or skill to deal effectively with the problem or because they harbor some negative attitudes toward alcoholics.

With the increased availability of alcohol treatment resources, physicians need not feel that, if they bring up the subject with their patients, they will automatically have to

David C. Lewis, MD, *Associate Professor of Medicine, Donald G. Millar Distinguished Scholar in Alcoholism Studies, Director of the Program in Alcoholism and Drug Abuse, Brown University Program in Medicine, Providence, Rhode Island; Director of the Division of Alcoholism and Substance Abuse, Roger Williams General Hospital, Providence, Rhode Island; Coordinator of Addiction Services, Providence Veterans Administration Medical Center, Providence, Rhode Island.*

shoulder the full weight of continuing treatment. Assistance is available from community resources, detoxification centers, outpatient clinics, hospitals, family service agencies, and Alcoholics Anonymous.

Goals of Intervention

Total abstinence from alcohol is the goal for most patients, but the success of treatment should not be measured solely by whether the patient stays "on the wagon." Reducing the frequency and severity of drinking episodes and making some improvement in lifestyle can be viewed as significant progress. Although some patients cannot be helped by even the most sensitive and skilled physician, the majority can, over time, achieve control over their drinking behavior.

Physician's Role

The development and maintenance of doctor-patient rapport is a key factor in achieving success with the alcoholic patient. A physician who is already known and trusted by the patient has an advantage when it comes to helping him or her recognize the problem, eliciting and understanding the history, encouraging the patient, and providing ongoing support. Because people who have lost control of their drinking are highly sensitive to rebuff, it is important that physicians accept them with the same concern they would give patients suffering from any other chronic disease, and that they avoid showing impatience or disapproval. Many patients who will accept help from an internist, surgeon, or family physician are reluctant to go to a psychiatrist or alcoholism clinic. Whether the physician takes primary responsibility for the alcoholic patient's treatment or coordinates treatment through other services, he or she should remain a consistent source of support.

Diagnosing the Alcoholic

Often the problem drinker will conceal or deny drinking habits and their consequences. Unlike conscious lying, denial is a psychological defense mechanism that prevents a person from seeing the relationship between excessive drinking and other problems such as physical difficulties, trouble at home or at work, or trouble with the law. Clarifying this relationship for patients is usually very helpful, if it is done gently and firmly.

States That May Accompany Excessive Use of Alcohol

- Systolic hypertension
- Pancreatitis
- Cardiomegaly
- Peripheral Neuropathies
- Myopathies
- Hematological abnormalities, such as anemia and thrombocytopenia

Many other patients, in contrast, are aware that they have a drinking problem and are ready to discuss it. If the doctor seems to avoid the topic, the patient may interpret this reaction as a tacit license to continue drinking. In general, physicians do not confront their alcoholic patients enough. A comment like "You look a little under the weather" may be enough to start the patient talking about his or her drinking. Even if initial questions provoke resentment or denial, the physician will have opened the door for the patient to return when he or she feels ready.

It is important to take a careful medical history and to be alert to the possibility that problem drinking may explain physical problems. The medical history should be specific about the patient's drinking habits: how often he or she drinks, how much, what kind, on what occasions, and how long he or she has had difficulty controlling consumption. The physician should note the manner in which the patient responds, as well as the content of the response. Vague or defensive answers are important clues to a possible underlying alcohol problem. A history of alcohol withdrawal symptoms, blackouts, or seizures often indicates uncontrolled drinking. It is also important to learn whether the patient uses any other psychoactive drugs, because of their dangers in combination with alcohol. Questions to identify the longest "dry" period the patient ever achieved, how it was accomplished, and how he or she felt during that period can help the physician in understanding the dynamics of individual drinking behavior.

Although the history is the most important element in the early diagnosis, a number of other clues may point to drinking as the underlying problem. Alcohol may be a factor in a variety of gastrointestinal complaints, most frequently a manifestation of alcoholic gastritis. Physical examination revealing hepatomegaly or hepatic tenderness should also alert the physician to a possible alcohol problem. Long and varied lists of disease states, signs and symptoms accompany the excessive use of alcohol and are usually caused by its direct toxic effects.

Alcoholism may be an important factor in abnormalities in mental status, such as defects in judgment and memory function, and it is high on the list of differential diagnoses whenever a patient has seizures. Because the rate of excessive drinking in the population is high and alcohol is directly toxic to so many tissues, the physician should be constantly on the lookout for alcohol as a possible factor in common conditions that otherwise might not be explained. Frequent injuries or accidents, for example, should alert the physician to the possible role of alcohol.

Equally important are unexpected changes in personality and social behavior. The first manifestation of alcoholism may be a mood change, often depressive, or a deterioration in job performance or family stability. These clues indicating changes in behavior should receive the same attention as a history of excessive drinking or the occurrence of physical complications.

If patients are unsure whether they have a drinking problem, the doctor can suggest that they set a drinking limit and see if they can stick to it, or keep track of how much and on what occasions they drink over a given period of time. Some patients can be persuaded to acknowledge their drinking problem by seeing the results of physiological tests (for example, liver enzyme abnormalities) that show the effects of drinking on their health.

Someone other than the patient may alert the physician to the disease: spouse, family members, friends, or employers. The doctor

---

Outpatient Alcohol Treatment Programs

The Rhode Island Department of Health licenses detoxification centers and halfway houses throughout the state. A resource directory of Alcoholism Services for Rhode Island has been published by the Junior League of Providence, Inc. Copies of this directory can be obtained by contacting:

Council for Community Services, Inc.
229 Waterman Street
Providence, Rhode Island 02906
Telephone: 861-5550

This directory contains a complete list of alcoholism services in Rhode Island including inpatient, outpatient and residential treatment facilities.

For additional referral information, contact:

Alcoholics Anonymous
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Room 201
Providence, Rhode Island 02903
Telephone: 331-2047

Rhode Island Division of Substance Abuse
Rhode Island Medical Center
Building 303 — General Hospital
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Telephone: 464-2091

Sources of Information about Alcoholism

C. S. Mullin, *The Office Treatment of the Alcoholic Patient: A Guide for the Physician* (Boston). Available from Division of Alcoholism, Massachusetts Department of Public Health, 755 Boylston Street, Boston, MA 02116.

The National Clearinghouse for Alcohol Information (NCALI), part of the National Institute on Alcohol Abuse and Alcoholism, collects and distributes information on all aspects of alcoholism. Write: NCALI, Box 2345, Rockville, MD 20852.

F. A. Seixas, *Alcoholism: A Practical Synthesis for Physicians* (New York). This and several other publications to assist the physician are available from the National Council on Alcoholism, 733 Third Avenue, New York, NY 10017.

J. Westermeyer, *Primer on Chemical Dependency: A Clinical Guide to Alcohol and Drug Problems* (Baltimore: Williams and Wilkins, 1976).

can often involve the spouse and significant others in discussions about the patient's condition in order to clarify the diagnosis for both the patient and the physician. Family involvement early in the diagnosis paves the way for their involvement in the treatment of the problem.

Intervention Strategies

In caring for the alcoholic, the doctor and the patient should develop a psychological contract, usually informal, that makes plain the expectations and responsibilities of each. Some suggestions for such an understanding are shown in the box below.

The major support sustem available to the patient is Alcoholics Anonymous (AA). This well-known organization offers many patients needed activity, emotional support from others in similar circumstances, practical advice, self-help literature, and access to someone who understands whenever the patient needs help. Doctors should familiarize themselves with the philosophy and techniques of AA and keep some of their literature on hand. Patients who are reluctant to join the organization may still benefit from talking to AA members.

Family members frequently need help in understanding their feelings toward the alcoholic and how their reactions are important in both encouraging or discouraging the progress of the illness. They may negatively reinforce a patient's behavior by moralizing, scolding, or undermining self-esteem. Often behind much of family members' reaction to the alcoholic is the feeling that the drinking is their fault and that they should be able to stop it. Two groups related to AA that educate and support the families of alcoholics are Al-Anon (for spouses) and Alateen (for teenage children).

When the diagnosis of significant uncontrolled drinking is made, the physician should consider the possibility of inpatient care to

---

A Psychological Contract between the Patient and the Doctor

Patient Agrees to:

- Be open with the doctor in reporting his or her drinking behavior and any problems related to drinking.
- Try for complete abstinence until the next visit, and not use a drinking episode as a reason for breaking an appointment.
- Be conscientious in keeping appointments or notifying the doctor if unable to do so.
- Not expect the doctor to rescue him or her from drinking-related crisis (i.e., trouble with spouse, employer, the law).
- Take any medication prescribed exactly as directed.
- Encourage family members to attend any pertinent meetings suggested by the doctor.
- Keep the doctor informed about any changes in his physical, mental, or social circumstances that might affect the course of treatment.

Doctor Agrees to:

- Explain his or her candid view of the consequences of the patient's drinking and respond to any questions.
- Refrain from reproving the patient for any drinking episodes or from using them as a reason to terminate treatment; instead, discuss lapses with a view to preventing recurrence.
- Refrain from rescuing the patient from the consequences of his or her drinking, except insofar as direct medical treatment may be needed.
- Carefully explain the use of any medication prescribed.
- Involve the family and other supportive people or groups in the intervention process whenever possible.
- Remain available and supportive to the patient and prepared to renegotiate this understanding in light of changes in the patient's circumstances or needs.

interrupt the syndrome of withdrawal symptoms followed by drinking bouts. A short hospitalization has several advantages: it removes the patient from sources of alcohol and the settings in which he or she drank; it protects the patient from some of the dangerous effects of withdrawal during detoxification; it allows the physician to obtain some detailed baseline data; and it starts the patient on the recovery process.

In addition to general hospitals, a number of hospitals specialize in the care of alcoholics and usually combine a short-term detoxification program (lasting a few days) with a longer educational and rehabilitative effort (lasting a few weeks). These hospitals welcome referrals from physicians. Abstinence may be particularly difficult for people whose social life revolves around their "drinking buddies," or for those who drink to stave off loneliness and boredom (retired people, for example). These people may benefit from a short hospitalization and, after discharge, from some attention to the development of new social activities.

Several outpatient alcohol treatment programs provide counseling on a continuing basis for the problem drinker and alcoholic. Some of these are clinics of general hospitals, but most are community agencies.

Some doctors feel that an admitted drinking problem can be handled by pharmacological intervention, by substituting a seemingly nontoxic drug, usually the benzodiazepines (Librium® or Valium®) for the toxic alcohol. Drug intervention can be helpful with carefully selected patients. Too often, however, it is problematic, since alcohol-dependent patients may use drugs not as substitutes for alcohol but in addition to it. Many alcoholic treatment specialists believe that the use of sedatives and hypnotics should be avoided with alcoholic patients, except for the treatment of alcohol withdrawal.

Disulfiram (Antabuse®) also can be used as a deterrent to continued drinking, if the patient is willing to take the drug daily and understands the risks of the Antabuse®-alcohol reaction. (The dose is 0.25g each day, after an initial loading dose of 0.5 g daily for seven days). Some patients use Antabuse® as added "insurance" during their initial period of sobriety; the first six months is usually the most difficult time.

Information From Alcoholics Anonymous

Alcoholics Anonymous publishes concise, informative pamphlets for physicians and for patients, spouses, and other family members. Write:

Alcoholics Anonymous World Service, Inc.
P.O. Box 459, Grand Central Station
New York, New York 10017

Al-Anon or Alateen
P.O. Box 182, Madison Square Station
New York, New York 10010

Although Antabuse® is used most effectively in a structured treatment program, many physicians have found the drug useful in their practices. The doctor should be aware of a potential conflict for patients active in AA, because AA members frequently disapprove of all pharmacological supports. The patient may feel caught in the middle between the physician and the AA group. Since many patients can handle this conflict, however, the physician should not automatically refrain from drug intervention, if he or she is convinced that it is in the patient's best interest.

Whether or not the physician assumes the primary treatment role, his or her influence on the patient's progress can be considerable. The doctor's understanding of an attitude toward the problem of uncontrolled drinking can make a critical difference in the recovery process. It is important for the doctor to treat the complications of alcoholism, but it is equally important for him or her to make an early diagnosis and focus attention on the process by which the patient achieves control over drinking. In working with the patient, family, employer, and numerous community support systems that already deal with this illness, the physician can play a significant role.

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Components of Change in Rhode Island's Physician Supply, 1974-1977

Components Of Change Analysis Provides A Clearer Understanding Of The Dynamics Of State's Physician Supply

Donald C. Williams

The total number, principal specialties and other characteristics of physicians providing care to the population are important concerns in health system planning activities in Rhode Island and other states. Typically, available data describe only the characteristics of an area's physician supply at given times (eg, 1975, 1976, and so on). To date little information has been available regarding the numbers and characteristics of physicians entering practice, leaving active practice, and changing specialties between periods. Consequently, knowledge of the dynamics of physician supply in specific areas has been limited.

However, the Physician Relicensure Survey Data gathered in Rhode Island since 1974 by the Cooperative Health Statistics System (CHSS) at Rhode Island Health Services Research, Inc (SEARCH) provides the information necessary to describe and analyze these "components of change" in Rhode Island's active physician supply. Table I summarizes both the supplies of physicians and components of change in physician supplies for the period 1974-1977. The sum of "Increases", "Decreases", and "Specialty Changes", (ie, the "components of change") which occur between two consecutive periods (eg, 1974 and 1975) equals the difference in the supply data for those periods. Figure I details the physician specialty classification scheme utilized in constructing Table I.

Donald C. Williams, *Supervising Health Planner, Office of Health System Planning, Rhode Island Department of Health, Providence, Rhode Island.*

The components of change information allow more complete understanding of the dynamics of Rhode Island's physician supply than is provided by supply data alone. For instance, physician supply data indicate that after two successive increases in the total number of physicians in 1975 and 1976, total supply declined by 42 in 1977. Without viewing the components of change, little more can be determined. However, the components of change analysis indicates that the 1977 decline was due to an increase in the number of physicians leaving active practice, rather than a significant decrease in the rate at which physicians entered active practice in the state in 1977.

Table I also allows the components of change to be analyzed by specialty groupings. For example, the supply of primary care physicians rose from 620 in 1974 to 641 in 1975, after which it declined to 640 in 1976, and, more precipitously, to 603 in 1977. Table I shows that in both the 1974-1975 and 1975-1976 periods the net result of "Increases" and "Decreases" was growth in the supply of Primary Care physicians (1974-1975, $+64-39=+25$; 1975-1976, $+67-58=+9$). Only in the last period (1976-1977) did the "Increases" fall short of "Decreases"

Table 1. Nonfederal Physicians (MDs and DOs) Active in Patient Care in Rhode Island: Supply and Components of Change, 1974-1977.

Period	Data Item	Physician Specialty Category				
		Total	Primary Care	Surgical Specialties	Medical Specialties	All Other NEC*
1974	Supply of Nonfederal Physicians Active in Patient Care	1391	620	316	152	303
1974-1975	Components of Change					
	Increases					
	Previously Inactive	32	14	6	4	8
	New Licenses	101	50	15	5	31
	Total	133	64	21	9	39
	Decreases					
	Newly Inactive	54	21	8	5	20
	License Not Renewed	37	18	5	1	13
	Total	91	39	13	6	33
	Specialty Changes					
	From					
	Primary Care to	44	x	4	31	9
	Surgical Specialties to	15	9	x	0	6
	Medical Specialties to	29	23	4	x	2
	All Others, NEC* to	17	8	6	3	x
	Total	105	40	14	34	17
1975	Supply of Nonfederal Physicians Active in Patient Care	1433	641	323	160	309
1975-1976	Components of Change					
	Increases					
	Previously Inactive	21	8	2	4	7
	New Licenses	139	59	24	11	45
	Total	160	67	26	15	52
	Decreases					
	Newly Inactive	93	35	18	14	26
	License Not Renewed	55	23	9	5	18
	Total	148	58	27	19	44
	Specialty Changes					
	From					
	Primary Care to	47	x	6	30	11
	Surgical Specialties to	7	0	x	3	4
	Medical Specialties to	29	26	0	x	3
	All Others, NEC* to	15	11	2	2	x
	Total	98	37	8	35	18
1976	Supply of Nonfederal Physicians Active in Patient Care	1445	640	323	162	320
1976-1977	Components of Change					
	Increases					
	Previously Inactive	47	13	14	5	15
	New Licenses	104	51	14	13	26
	Total	151	64	28	18	41
	Decreases					
	Newly Inactive	135	50	33	11	41
	License Not Renewed	58	37	2	7	12
	Total	193	87	35	18	53
	Specialty Changes					
	From					
	Primary Care to	38	x	0	29	9
	Surgical Specialties to	8	0	x	3	5
	Medical Specialties to	24	19	2	x	3
	All Others, NEC* to	10	5	2	3	x
	Total	80	24	4	35	17
1977	Supply of Nonfederal Physicians Active in Patient Care	1403	603	312	173	315

*Not Elsewhere Classified (NEC)

Figure 1. Description of Physician Specialty Categories Used in Table 1.

Group	Includes:
"Primary Care"	Family[1] and General Practice, Internal Medicine, Gynecology, Obstetrics, Obstetrics and Gynecology, Gynecological Surgery[2], Obstetrics and Gynecological Surgery[2], Pediatrics
"Surgical Specialists"	Broncho-Esophagology[1], Laryngology[1], Otology[1], Otorhinolargyngology, Rhinology[1], Ophthalmology and Otorhinology[2], Ophthalmology and Otolargyngology[2], Ophthalmology, Colon and Rectal Surgery[1], General Surgery, Abdominal Surgery[1], Surgery, Orthopedic Surgery, Urological Surgery, Cardiovascular Surgery, Hand Surgery[1], Head and Neck Surgery[1], Neurological Surgery, Pediatric Surgery[1], Peripheral Vascular Surgery[2], Plastic Surgery, Thoracic Surgery, Traumatic Surgery, Urology, Proctology
"Medical Specialists"	Allergy, Cardiovascular Diseases, Cardiology[2], Dermatology, Dermatology and Syphilis[2], Diabetes[1], Gastroenterology, Geriatrics, Neurology, Child Neurology[1], Neurology and Psychiatry[2], Pediatric Allergy[1], Pediatric Cardiology[1], Physical Medicine and Rehabilitation, Pulmonary Diseases, Rheumatology, Endocrinology, Hematology, Infectious Diseases[1], Neoplastic Diseases[1], Nephrology[1], Peripheral Vascular Diseases[2]
"All Others, NEC"	All other specialties not classified as "Primary Care", "Surgical Specialists", or "Medical Specialists"

[1]Listed only on American Medical Association list of specialties.
[2]Listed only on American Osteopathic Association list of specialties.

(+64-87=-23). The number of "Increases" to the Primary Care category was relatively constant (64, 67, and 64, respectively, in each period), while the number of "Decreases" grew (39, 58, and 87, respectively). However, a different picture emerges when "Specialty Changes" are included. In each period the number of "Specialty Changes" from Primary Care exceeded those into Primary Care (1974-1975, +40-44=-4 net; 1975-1976, +37-47=-10 net; 1976-1977, +24-38=-14 net). The overwhelming majority of the "Specialty Changes" away from Primary Care were to the Medical Specialties, perhaps indicative of the postulated ultimate subspecialization of the growing numbers of internists.[1] While specialty changes from the category of Medical Specialists to Primary Care were substantial, those specialty changes were always less than the flow of Primary Care physicians to the Medical Specialties. There is less evidence of cross-group specialty changes between the "Primary Care" group and either the "Surgical Specialties" or the "All Other" categories.

Components of Change

The components of change analysis can be altered to accommodate more disaggregate physician specialty groupings or to include physician characteristics, such as age, sex, practice location, and MD or DO licensure. The utility of the components of change analysis will be increased as additional years of information are incorporated into the data base.

Summary

The components of change analysis represents a valuable new approach for describing and analyzing the dynamics of Rhode Island's physician supply.

References

1Wechsler H, Dorsey JL, Bovey JD: A follow-up study of residents in internal medicine, pediatrics and obstetrics-gynecology training programs in Massachusetts. N Engl J Med 298:15-21, 5 Jan 78

Department of Health
75 Davis Street
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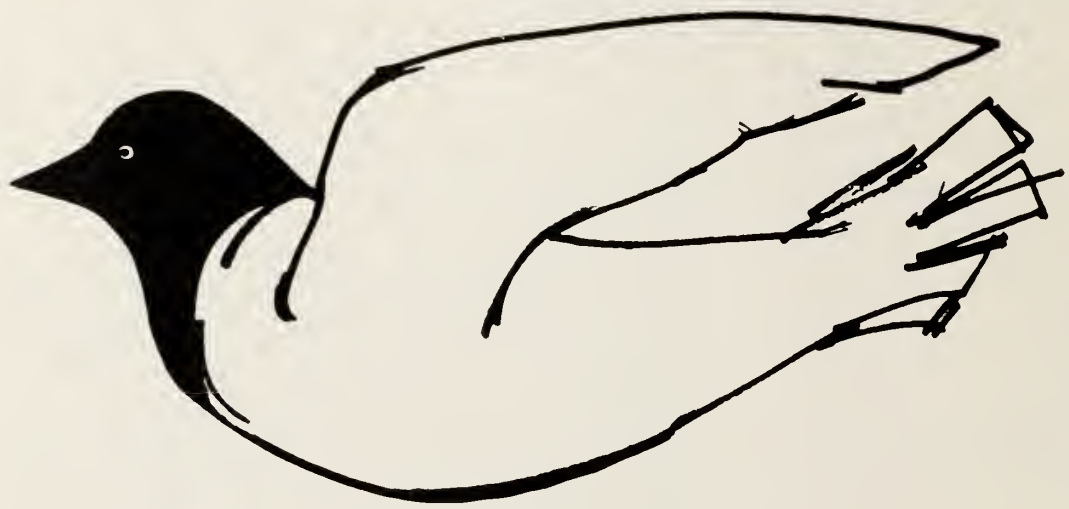

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†See Warnings, Precautions and Adverse Reactions.

See following page for prescribing information.

Reference:
King, J.C. and Starkman, N.M. Evaluation of an antispasmodic. Double-blind evaluation to control gastrointestinal spasms occurring during radiographic examination. A preliminary report. Western Med 5:356-358, 1964

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Do not rely on the use of the drug in the presence of complication of biliary tract disease. Investigate any tachycardia before giving anticholinergic (atropine-like) drugs since they may increase the heart rate. With overdosage, a curare-like action may occur. ADVERSE REACTIONS: Anticholinergics/antispasmodics produce certain effects which may be physiologic or toxic depending upon the individual patient's response. The physician must delineate these. Adverse reactions may include xerostomia, urinary hesitancy and retention; blurred vision and tachycardia; palpitations; mydriasis; cycloplegia; increased ocular tension, loss of taste; headache, nervousness; drowsiness, weakness; dizziness; insomnia; nausea, vomiting; impotence; suppression of lactation; constipation, bloated feeling; severe allergic reaction or drug idiosyncrasies including anaphylaxis, urticaria and other dermal manifestations; some degree of mental confusion and/or excitement, especially in elderly persons; and decreased sweating. With the injectable form there may be a temporary sensation of lightheadedness and occasionally local irritation. DOSAGE AND ADMINISTRATION: Dosage must be adjusted to individual patient's needs.

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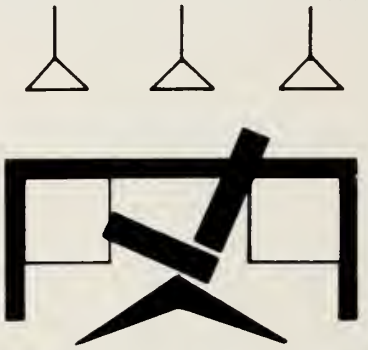

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Less than two months later a surgeon removed a cancer in this woman's severely contused left breast.

"Could this tumor have been caused by that cab injury?" — that was the question put to me by the claims examiner of _____ Insurance Company of Providence, RI. He continued, "We are faced with a quarter of a million dollar suit. Any merit to the claim?" "Cancer is not caused by a single blow," I reassured him. "We shall send you all our data. See what you can do with it."

Later I felt less happy about my optimistic reply as I contemplated the weight of the apparent evidence; and even more so, after I'd read a letter from the plaintiff's surgeon to the patient's attorney, stating: "The original premise that trauma may have a casual effect in cancer is still in a gray area. As far as breast tumors go, I think there have been some cases in the past to which the decision has been in favor of trauma initiating tumor."

John S. Dziob, MD, FACS, *practitioner in General Surgery, Providence, Rhode Island; Surgeon, University Health Services, Brown University, Providence, Rhode Island, retired.*

Day after delightful summer's day, I plodded over the warm sands of Wickford Beach, RI, only dimly aware of the raucous, melancholy screech of the wheeling gulls and rushing salty surges of the incoming tides, chewing away at the facts and digesting the views in the current medical literature, until at last I thought I had the answer.

A scholarly, technical exposition would most likely fall on unresponsive, bored ears. That badly discolored and swollen breast with its cancerous nodule could well be understood as coincidental findings by the medical mind. But the evidence must seem overwhelmingly cause and effect to the layman, the jury, and even to legal counsel. With such thoughts uppermost in my mind and with the spectre of a quarter million dollars in jeopardy, I addressed the following analysis of the case to the claims agents.

Case Analysis

I shall review the history, the findings on physical examination, and the pathologist's reports in the case of Mrs. _____, as they are recorded in the accounts of her physician and of her surgeon, as well as in the register of her stay in _____ Hospital — all pertaining to the patient's injuries sustained in a taxi accident in which whe was a passenger, interjecting interpretation and emphasis of significant facts as they appear to me.

Mrs. _____ fell forward, according to her physician's letter, against the back of the front seat of a taxi, "striking her left breast" and sustaining a contusion of the left breast

and an "abrasion of the right knee over the knee cap." The latter seems to have been of no consequence, and healed without incident.

There apparently was no trauma to the right breast or, if any, of such a trivial nature as not to have shown any subjective (no pain or discomfort) or objective signs (bruising, discoloration). Also there was no indication of head injury, whiplash trauma, or bone damage to the thoracic cage or elsewhere. She was able to get up on her own, resuming her seat, as the cab continued on its way. As accidents go, so far, it sounds like a minor affair indeed. The following day she consulted her physician. He noted that there was "swelling and bluish discoloration of the entire left breast with swelling and tenderness throughout. Furthermore, on palpation there is no palpable tumor present."

His last observation, "no palpable tumor present," cannot be considered as definitive, since the presence of tenderness and swelling preclude the performance of a conclusive examination. Moreover, HS Gallagher,[1] states that "before mammography, physicians were missing 25 per cent of relatively advanced cancer on initial examination." Even more strongly in this vein, Monkman et al[2], contend that "previous integrity (normalcy) of the affected part is virtually impossible to ascertain accurately even if the results of a recent physical examination by a qualified and conscientious physician were negative."

This description would seem to indicate that the broad surface of the back of the front seat struck the left breast "head-on". But how could it do so without simultaneously injuring the right breast? More likely, she fell obliquely forward with the body twisted enough so that only a portion of the left breast received the impact. Such a conclusion is also suggested by the microscopic sections of the subsequently excised left breast. This will be discussed in detail below.

On examination one week later, according to her doctor, "the bluish discoloration of the left breast has increased to 5 inches by 4 inches, and some induration is now associated with it." Two weeks post injury "the discoloration is persisting in the left breast, and there is now an adherent mass, 3 inches by 2 inches, in the center of the area of discoloration, but the tenderness is less."

Following a 14-day interval (one month post accident), the patient was seen again. The persistence of the discoloration and induration prompted the physician to seek surgical consultation.

The documentation of the "adherent mass" in the left breast is not too precise, and a more accurate location of it becomes clear from the consulting surgeon's initial examination. It describes the skin of the left breast as showing "bruising present through the areola and on the medial aspect of the breast at about the 9 o'clock radial axis, extending out to the periphery near the sternum; also an area of thickening on the edge of the areola at 10 o'clock, extending out to the midzone . . . with local dimpling of the breast." In addition, the surgeon found something not previously described: "A thickened area at the periphery in the upper outer quadrant of the left breast at 2 o'clock about 2 cm in diameter. It is not fixed to the skin or to the chest wall;" and finally, the "left lymphatic areas show no adenopathy."

As to the site of the blow on the left breast, which breast incidentally is a fairly large one, measuring 16 x 18 x 4 cm after surgical removal, it is interesting and quite important to mark the references to this site throughout the records. Under "Impression" on the surgeon's history sheet, we find: "This patient has a tumor in the upper outer quadrant of the left breast, and a recent history of trauma with a thickening of the medial aspect of the same breast." Then again, in the "Admission Note," he writes: "This patient has a suspicious finding on mammogram with thickening in the upper quadrant of the left breast. She recently injured the breast, but the bruise presents in the opposite quadrant of the breast." Finally, he quotes the pathologist's description of the left breast removed at operation as showing "areas of coagulation necrosis of the dermis and epidermis of the infero-medial quadrant of the left breast where a bruise had been present."

These references make the site of trauma to the left breast pretty clear, namely, its inner lower half and not the upper outer quadrant where the malignant nodule was found. Nowhere in the records is there mention of any discoloration or other evidence of injury to the upper outer quadrant of the left breast. Apparently, the force of the trauma had some-

how been confined to the inner lower half of this mammary gland.

A mammogram was interpreted as showing "in the upper outer quadrant at 2 o'clock an area highly suspicious, that should be biopsied." Accordingly, the patient was admitted to _____ Hospital with a diagnosis of "tumor of left breast, upper outer quadrant," and a "contusion with thickening left breast, medial lower quadrant."

At operation the surgeon removed a wedge of tissue from the upper quadrant of the left breast, in the center of which a small nodule was found on frozen section examination to be carcinoma. The defect was sutured, and a modified radical mastectomy followed. The postoperative course was in general uneventful, and the patient was discharged home with a well healing wound on the 7th postoperative day.

A consideration of the pathologist's description of the various sections of the excised left breast, both the gross and microscopic, is instructive. It enables us to differentiate the nature of the two lumps present in this breast: one, a benign traumatic lesion of recent origin (1½ months); the other, a malignant tumor of greater age. In addition, it gives some idea of the type of force that had hit the breast and the parts of the breast involved. It also shows that this mammary gland had not been a healthy one. Finally, it reveals that all of the lymph nodes removed at operation were free of cancer.

The excised left breast measured 16 x 18 x 4 cm overall — a fairly large breast. The areola and periareolar tissues appeared ecchymotic with a thickened nodule of skin "just off the areola at 10 o'clock." As the breast was sectioned in the gross, the pathologist saw "diffuse fibrous thickening and small cysts containing greasy material" — a good description of fibrocystic disease.

Under the microscope, the cutaneous thickening from the inferomedial aspect of the left breast displayed coagulation necrosis of the dermis and epidermis; but no signs of any necrosis of the underlying fat, typical of direct blows to the mammary tissues[3]. The coagulation necrosis identifies the point of maximum impact; the peri-areolar tissues, so discolored in the gross, revealed microscopically only "acute hemorrhage within the skin of the dermis," but without necrosis, signifying an area of lesser traumatization. Moreover, there is no mention of hemorrhage in the skin of the upper outer quadrant of the breast, the site of the cancer.

These findings suggest that the sudden stop of the taxi pitched the slightly turned body of the woman forward with the lower, inner, sagging, presenting portion of the left breast striking, scraping, and sandpapering across the back of the front seat in her fall to the floor of the cab. Such trauma would cause its severest damage to the skin of the left breast and much less injury to the deeper layers, with the greatest impact at the leading lower quadrant of the breast, diminishing toward the nipple and areola. The shearing effect would tear vessels in the skin, causing bleeding and swelling and tenderness in that part of the breast. This was the presenting picture the day after injury.

The microscopic pathology of the firm tissue from the upper outer quadrant of the breast is described as "a small tumor nodule in which cords of hyperchromatic cells infiltrate surrounding fat accompanied by dense fribrous stroma; there is central necrosis." Additional firm tissue from the same area shows "dense fibrous stroma and dilated ducts containing atypical intraductal hyperplasia." This adds up to a picture of an infiltrating adenocarcinoma in a field of fibrocystic disease. Finally, in the sections from the distal or lower breast there are dilated ducts filled with amorphous material indicating again the presence of fibrocystic disease throughout, — a condition not limited to the upper outer quadrant.

With no evidence of gross trauma to the upper outer side of the left breast, such as discoloration, and no mention of microscopic hemorrhage, which is so evident in the areolar tissue, it would appear that the central necrosis in the tumor nodule with its associated dense fibrous stroma is a manifestation of a process not of recent origin, but rather of a more established condition, certainly older than the histopathology of the traumatic thickening from the opposite side of the breast. It also suggested some degeneration from an inadequate, older, choked-off blood supply. And lastly, microscopic sections of all the ten lymph nodes removed at surgery from the axilla "are free of metastatic tumor."

On the basis of the critical appraisal of this body of information, let us summarize what we have learned:

A 56-year-old, married female is pitched from her seat in a taxi, sustaining a blow across the lower inner half of the left breast from the back of the front seat in her fall to the floor. The right breast escapes injury. There is an abrasion of the right knee. Much ecchymosis results overnight from the scraping type force that contused and tore the tissues and capillaries in the skin of the medial portion of the breast including the areola, but did not do much damage to the deeper, underlying tissue. It did very insignificant harm, if any, to the opposite or upper outer quadrant of the breast. The slow resolution of the extensive discoloration and the persistence of the thickening of the medial breast at the edge of the areola, still present after four weeks, gave concern to her original physician. The surgeon to whom she was referred confirmed the traumatic thickening in the medial segment of the breast, but also found a tumor in the upper outer non-traumatized portion of her mammary gland. A mammogram revealed the latter as suspicious of malignancy; subsequent biopsy verified it as carcinoma. The breast was removed surgically including the lymph nodes in the left axilla, but excluding the pectoral muscles. Representative microscopic sections of left breast tissue were characteristic of fibrocystic diasease, traumatic fibrosis of a segment of the inner medial portion, an adenocarcinoma of the upper outer segment, and negative left axillary lymph nodes.

Hence, one must conclude that the cancer in the upper outer quadrant antedated the trauma, and consequently could not have been caused by it.

What would lead to this conclusion? — both the size of the lesion and its histopathology. It would be unusual indeed for a cancerous nodule to attain 2 cm in size in a matter of 4 to 6 weeks. J.B. Haberman[4] states: "A palpable cancer must be considered an old cancer." This axiom is supported by a study of C. Toker[5] based on breast biopsies of 4,000 patients, as regards the time interval for the change from cancer in situ to invasive carcinoma. One case in the series developed invasive cancer or a nodule one cm in diameter in just under a year after its discovery by biopsy as a small cell dysplasia. The remainder of the invasive tumors took anywhere from 2 years to 15 years to reach the same size.

Further corroboration is to be found in the observation of J. Gershon-Cohen[6] that a tumor with a doubling time of 23 days (fairly fast growing) must multiply for about 2 years (30 doublings) to achieve a diameter of 1 cm. It will be recalled that the surgeon in our case in his initial examination documented the size of the tumor in the upper outer quadrant of the left breast as 2 cm. Hence it must have been growing for well over 2 years.

Furthermore, the cellular structure of this malignant nodule denotes greater age than that of the traumatic non-malignant thickening in the infero-medial aspect of the same breast.

Thus the cancer must have been there for two years at least before the present trauma occurred. What other particulars indicate that the malignancy had preceded the accident and had not been caused by it? There are several. The fact that the upper outer quadrant of the breast had not been subjected to significant, if any, trauma in the first place, as already pointed out. In reply to an objection that there might still have been sufficient force transmitted to the area, Monkman's statement "that the trauma must be severe enough to stimulate tissue proliferation" would apply since there is no microscopic evidence of such proliferation. Further, the injured portion of this diffusely fibrocystic breast, considered by some to be a pre-cancerous stage, did not respond to the blow with a cancer at this precise point, but rather produced only the typical coagulation necrosis of trauma. The neoplasm in fact appeared in the upper outer quadrant, where 40-60 per cent of all human breast cancers occur.[10] Finally, the atypical intraductal hyperplasia in the upper outer area represents a pre-cancerous lesion.[9,10,12] All of these observations taken together indicate strongly that cancer may well appear spontaneously in the absence of any external stimulus.

The fact that "a single blow does not cause cancer" is well documented elsewhere in the medical literature. L.K. Ferguson[11] states: "There is no evidence that a single local trauma is a factor in the production of malignancy." Also, Monkman[2] writes that "Stewart's statement,[12] 'I would refuse to entertain even the suspicion that mammary cancer is cause by trauma,' reflects the opinion of most modern pathologists."

Moreover, the following surgical textbooks reiterate the same view: Babcock's,[13] Christopher's,[14] and Lichty & Soper's,[10] to name just a few published during the last 40 years.

One finds further substantiation that single uncomplicated trauma is not an excitant of cancer in data from the experimental laboratory and from statistical analysis. It is recognized that the recent upsurge of women's participation in contact sports in the colleges and elsewhere in the country has not produced a significant incidence of breast carcinoma.

Laborch[15] using various forms of mechanical trauma could not produce cancer in animals. Marsh[16] working with tumor susceptible mice failed to induce cancer by trauma. Finally, Foulds[17] employing vulnerable fowl also labored in vain. Perhaps our present case could be viewed as an experiment, fortuitously set up by nature to show quite dramatically that what holds true for animals also applies to the human female breast. A human mammary gland with fibrocystic disease, already involved by cancer and thus most certainly tumor susceptible, was struck a severe blow, but subsequently failed to show on microscopy any malignant changes at the traumatized site.

Statistical studies also support the concept that no single trauma has ever resulted in cancer[2]: "The number of cases of trauma-associated malignancies, when compared to the total number of injuries, is not statistically significant; ie, of 100,000 injuries, approximately 6 are associated with cancer. But the incidence of cancer in injured persons is about 1 in 700, which is the same incidence of cancer as in the general population." Also, "In war time when trauma is certainly rampant, no increase in the incidence of cancer is found." Moreover, "Football players and other athletes exposed to repeated severe single trauma do not have higher than average incidence of malignancies."

My own observation that neither physical education departments in our colleges, nor the parents of participating students — scientists, doctors, lawyers, educators, and others — seriously entertain the notion that trauma produces breast cancer. They would not sanction, approve, even encourage female involvement in Hockey, LaCrosse, Basketball, and other contact sports in our schools, but rather prohibit them.

The human female breast from time immemorial has been sucked and tugged by robust hungry infants; kicked by struggling, squalling children; mauled by drunken, ravishing, savagely-brutal marauders; and tweeked, squeezed, and bitten by impassioned, frenzied, orgiastic lovers. But the wisdom of the race has nowhere given rise to the taboo or warning: Do not bruise lest you provoke cancer.

"Scientific evidence," according to Monkman et al[2], "Unequivocally linking primary cancer with a single uncomplicated trauma, does not exist." Ewing's statement[16], that "traumas reveal more malignancies than they cause" is true and aptly put.

From our critical consideration, therefore, of the findings in the history, the physical examination, the operation, and the pathological specimens in this case, it becomes apparent that there was little significant force delivered or distributed to the upper outer quadrant of the left breast (site of the cancer); that the malignant nodule there antedated the trauma-induced, benign thickening in the opposite side of this breast; that the medical literature and laboratory experiments provide no evidence to support the contention or concept that a single blow is carcinogenic; and finally, that statistical analyses as well as the common experience of mankind confirms this.

It now behooves us to establish whether the trauma to the left breast resulted in any aggravation to this pre-existing cancer or incited any dissemination of malignant cells (metastasis).

How can a tumor be aggravated by trauma? It is fairly obvious that an increase in pain at the site of the lesion or its rapid expansion after the blow would signify this effect. The appearance of hemorrhage and the opening up of more channels to the influx of malignant cells with subsequent hematogenous spread would be readily apparent. The formation of an ulcer from the traumatic breakdown of the nodule, resulting in non-healing and extension locally, or the seeding of the surrounding area with carcinomatous tubercles within a reasonable time of the traumatic occurrence would be demonstrable. However, none of these untoward results were found in this case.

Pain, hemorrhage, and ulcer, are easily recognized. The acceleration of the growth of a tumor by trauma, however, with the appearance of complications of such growth is

much more difficult to establish. Ewing[18] points to two ways in which this can be done: 1. If trauma ruptures the capsule of an encapsulated tumor, relieving pressure and allowing of more rapid growth; and 2. if trauma introduces infection. Again, neither factor was evident in this case.

Having, then, disposed of the questions of causation and aggravation, a final consideration[15], metastasis. Was this present at the time of injury? Did it appear at any time in the postoperative period? The answer to both questions is in the negative. What facts are there to support such a statement? A preoperative x-ray study of the chest was reported as negative. All ten lymph notes removed at surgery were free of cancer. Moreover, the patient's surgeon wrote in his discharge summary: "One would elect to follow this case conservatively with no specific added modalities of therapy at this time."

Finally, there is experimental evidence along with some clinical observations, quoted by Monkmān et al[2], implicating trauma as a cause of localization of blood-borne metastases: "The more severe the trauma, the more the likelihood of metastasis occurring at the site of trauma." In the case of Mrs. _____, the injury involved the lower medial portion of the left breast and none as far as we know of the right one. The former has been removed surgically, thus neutralizing this as a potential site for any circulating cancer cells; the abrasion of her right knee healed promptly, and showed "no post-traumatic residual disease," as stated in the surgeon's letter written about five months after the accident. It is reasonable to conclude, then, that there is no recognizable metastasis currently present.

In closing, it must not be forgotten that this pre-existing breast tumor was providentially revealed, exposed, and spotlighted by the trauma, not caused or aggravated by it; that it was discovered and successfully treated as a result of the trauma; and that there is no evidence of current dissemination of the malignant process. Hence, it must follow that any future metastasis, should this occur, would be a manifestation of a natural course of events, triggered by alteration in the host-tumor relationship and not stemming from the accident.

Most writers on this subject echo the sentiments expressed by W C Hueper[20] when he writes: "It seems that the time has come when the concept of trauma as a primary causation of cancer should be permanently laid to rest by the medical and legal professions and should no longer form a subject of litigation before courts and compensation boards." It is our hope that this singular case might serve as one of the spikes to nail it down.

Epilogue

Academia, in picking up the gauntlet and entering the lists, had prevailed in the hurly-burly of the market place. The amount initially demanded by the complainant was a quarter of a million dollars. The amount finally accepted in settlement, a paltry three thousand five hundred dollars — a tacit acknowledgement, it would appear that there was no merit to their claim after all.

References

[1]Gallagher HS: Early Breast Cancer: Detection & Treatment. New York, John Wiley & Sons, 1975

[2]Monkman GR, Orwall G, Ivins JC: Trauma and oncogenesis. Mayo Clin Proc 49:157-163, Mar 74

[3]Berkow R (ed): The Merck Manual, ed 12. Rahway, Merck & Co, 1972, p 872

[4]Haberman JD: The present status of mammary thermography. CA 18:315-321, Nov-Dec 68

[5]Toker C: Time interval to invasive mammary carcinoma in patients with atypical small-cell dysplasia and in situ carcinoma. Mt Sinai J Med NY 43:53-56, Jan-Feb 76

[6]Gershon-Cohen J, Yiu LS: Mammography of thrombophlebitis. Surg 53: 657-661, May 63

[7]Fisher E: Breast cancer growth rate. CA 26:243, Jul-Aug 76

[8]Warren S: Minimal criteria required to prove causation of traumatic or occupational neoplasms. Ann Surg 117:585-595, Apr 43

[9]Humphrey LJ, Swerdlow M: Relationship to benign breast disease to carcinoma of the breast. Surgery 52:841-846, Dec 62

[10]Liechty RD, Soper RT: Synopsis of Surgery, ed 2. St. Louis CV Mosby, 1972, p 224

[11]Ferguson LK: Surgery of the Ambulatory Patient, ed 4. Philadelphia, JB Lippincott, 1966, p 293

[12]Stewart FW: Occupational and post-traumatic cancer. Bull New York Acad Med 23:145-162, Mar 47

[13]Babcock WW: Textbook of Surgery, ed 2. Philadelphia, WB Saunders, 1935, pp 834-854

[14]Christopher F (ed): Textbook of Surgery, ed 3. Philadelphia, WB Saunders, 1942

[15]Lubarsch O: Cited by Moritz AR, Helberg DS: Trauma and Disease. Brooklyn, New York, Central Book Co, 1959: Cited by Monkman GR, et al (2)

[16]Marsh: Cited by Moritz AE, et al (14): Cited by Monkman GR, et al (2)

[17]Foulds L: Cited by Moritz AE, et al (14): Cited by Monkman GR, et al (2)

[18]Ewing J: Bulkley lecture; modern attitude toward traumatic cancer. Arch Path 19:690-728, May 35

[19]Warren R, et al: Surgery. Philadelphia, WB Saunders, 1963

[20]Hueper WC: Medicolegal aspects of cancer. Am J Clin Pathol 25:116-125, 1955

[21]Gilbertsen VA: Survival of asymptomatic breast cancer patients. Surg Gyn Obstet 122:81-83, Jan 68

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CONTRIBUTIONS

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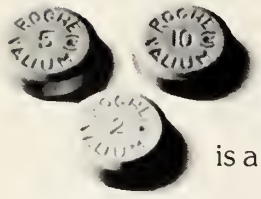
RADIOGRAPHIC CASE OF THE MONTH

NEWSLETTER

A character all its own.



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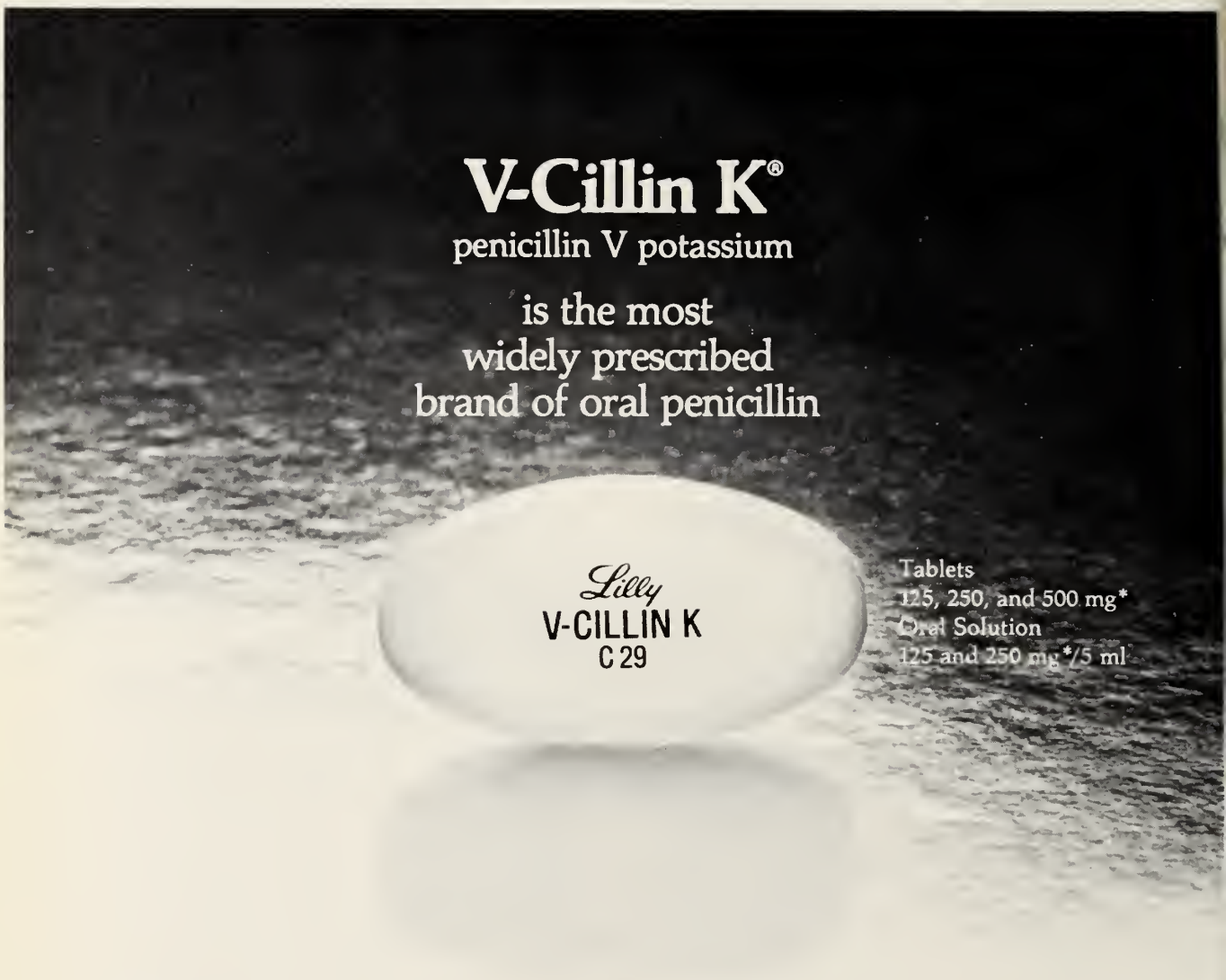

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Warnings: Serious, occasionally fatal, anaphylactoid reactions have been reported. Some patients with penicillin hypersensitivity have had severe reactions to a cephalosporin; inquire about penicillin, cephalosporin, or other allergies before treatment. If an allergic reaction occurs, discontinue the drug and treat with the usual agents (e.g., epinephrine or other pressor amines, antihistamines, or corticosteroids).

Precautions: Use with caution in individuals with histories of significant allergies and/or asthma. Do not rely on oral administration in patients with severe illness, nausea, vomiting, gastric dilatation, cardiospasm, or intestinal hypermotility. Occasional patients will not absorb therapeutic amounts given orally. In streptococcal infections, treat until the organism is eliminated (minimum of ten days). With prolonged use, nonsusceptible organisms, including fungi, may overgrow; treat superinfection appropriately.

Adverse Reactions: Hypersensitivity, including fatal anaphylaxis. Nausea, vomiting, epigastric distress, diarrhea, and black, hairy tongue. Skin eruptions, urticaria, reactions resembling serum sickness (including chills, edema, arthralgia, prostration), laryngeal edema, fever, and eosinophilia. Infrequent hemolytic anemia, leukopenia, thrombocytopenia, neuropathy, and nephropathy, usually with high doses of parenteral penicillin. (102175)

***Equivalent to penicillin V.**

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Aspirin Intolerance Should Be Considered in the Diagnosis of Unexplained Rhinitis, Nasal Polyps, and Eosinophilia

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Small, Post-Dates Infant with Severe Respiratory Distress

Clinical Pathological Conference

Siegfried M. Pueschel, MD Richard E. Frates, MD
Don B. Singer, MD

Soliditary Rhabdomyosarcoma of the Pericardium: A Case Report and Pathologic Discussion

Rare Tumor of the Pericardium Is Found To Be the Cause of Unexplained Congestive Failure

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Rhode Island Medical Society March 1980

Newsletter

James R. Clarkin, Editor

Ophthalmology in Rhode Island — 1980

Arthur I. Geltzer, MD

Gigantic steps forward have occurred in surgery, diagnosis, and treatment in ophthalmology and Rhode Island has kept step with these tremendous advances, and in many areas leads the country in initiating new modes of treatment and procedures. About 50 ophthalmologists, almost all of whom are board certified in their specialty, practice in the state. The Rhode Island Hospital has a very clinically active residency program. The positions in the program are highly sought after and many of the graduates have become clinicians and teachers in this area.

Brown Medical School has had a positive impact on the quality of eye care. Many ophthalmologists have been attracted to Rhode Island to join in the developing Department of Ophthalmology and Visual Sciences at Brown University. Rhode Island has attracted eye surgeons with special interest in retinal disease, diabetes, glaucoma, strabismus, ocular plastic, and nasal-lacrinal procedures. A symposium on vitreous surgery (an entire new area of eye surgery) took place under the auspices of Brown University at the Miriam Hospital in June 1979. It was attended by more than 50 ophthalmologists from Indonesia, Europe, and Canada as well as neighboring New England States. Vitreous surgery is now being performed in Rhode Island on patients with diabetes and retinal detachment who were previously considered inoperable.

Microscopic surgery, both for cataract and other diseases, has become commonplace in this state. Almost all of the hospitals have highly sophisticated microscopes and surgery is being carried out with fewer complications and far more precision than ever possible before. Intraocular lenses, under experimental protocol, are being implanted following cataract extraction where contact lens and spectacle correction are not possible. Most of the ophthalmologists have assumed a conservative stance using this new modality only in indicated situations because of the known increased risks of this procedure.

In the area of diagnostic techniques, computerized peripheral field apparatus is now available in our state. In addition, photography and fundus fluorescein angiography are provided at several institutions and private offices.

In the realm of therapy, laser photocoagulation has established new highs in the number of patients being treated in the different types of conditions now amenable to therapy. In the treatment of glaucoma, Timolol, a potent new drug, has been introduced in therapy.

Contact lens technology has improved. There are many new lenses on the market and many patients who previously could not be fitted with contact lenses are now able to wear lenses which provide them with good vision and comfort. Lenses are now available especially for post-operative cataract situations which are left on for extended periods of time — up to three to six months. There is still considerable work that has to be done in this field, but some of the advances are promising.

One negative factor seen in the field of eye care appears to be the use of drugs in optometric offices not under the direct care and supervision of an ophthalmologist (following the institution of the Optometric Diagnostic Drug Law in 1977). It has been reported that several patients have been referred to the Massachusetts Eye and Ear Hospital with complications from receiving these drops without medical supervision. It is hoped that there will be a reversal of this law before any catastrophic events occur and before there are further incursions into medical diagnosis and treatment by non-medically trained personnel.

On the more positive side, there has been a marked decrease in the number of beds and number of patient days in the hospital for eye related problems. At the same time there has been a marked increase in the number and variety of procedures. All in all the statistics show an encouraging increase in the quality and quantity of eye care. There is more referral in the community, more scientific exchange, and more good eye care. ■

The American Academy of Ophthalmology and the American Association of Ophthalmology are considering a merger. The academy, which had always concentrated on educational programs, has become active in socioeconomic matters as well in recent years. The association, on the other hand, was created 23 years ago specifically to deal with the socioeconomic and legislative areas of ophthalmology. The most important question relating to the merger is how to insulate the educational aspects of the new organization from its political aspects. Membership requirements are another issue that must be resolved before the merger takes place. The academy requires that its members be board certified and the association does not.

Reprinted from *The Hospital Medical Staff*, January 1980

Who's Who on the Staff

Jim Clarkin (left) is the Executive Director. His is the desk where the tough problems land. Jim coordinates all Society activities including committee and other meetings, and represents the Society in the community. He spent twenty years as a management representative negotiating contracts with unions and five years with Massachusetts Blue Cross. Prior to joining the Society, Jim was the administrator of the Bristol County Medical Center for twelve years.

Howard E. Lawton (right) is an Assistant Executive Director. Howard is the newest member of the staff, and is involved in a membership campaign, continuous reporting on legislative activities concerning medicine, and coordinating mediation and peer review activities. Like Jim, he brings to the post numerous years as a health administrator, including ten years with Newport Hospital as credit manager and assistant office manager, and over eighteen years with Aquidneck Medical Center.

Karen Challberg (left) is an Assistant Executive Director. She manages production of the journal and the newsletter, and coordinates the continuing medical education accreditation system, and some public relations activities. Karen came to the Society three years ago from Duffy & Shanley, Inc., Providence public relations and advertising firm, where she worked in the production department for one year. Prior to that she was a teacher for seven years.

Libia Rattigan (right) is Office Manager. Libby has been with the Society for ten years. She is Jim's executive secretary, so when you call the Society, she's probably the first one you speak with. She also coordinates the Society's major mailings, and details of the Annual Meeting and the Society's group insurance program. Libby came to the Society right out of school and has the distinction of having worked at the Society longer than any present employee.

Lou Buckham (left) is bookkeeper for the Society. Her job is to keep track of finances, not only for the Society itself, but also for the Providence Medical Association, the Medical Bureau, RIMPAC, and the journal. She helps out with membership mailings and other special jobs, too. Lou's hours are flexible, but she's always here when really needed.

Donna Rodrigues (right) is Howard's secretary, principally, and does other clerical work for the Providence Medical Association, the Medical Bureau, and the journal as time allows. She worked for five years as a secretary at Bartlett Company, Seekonk, Massachusetts, prior to coming to the Society about three years ago. By the sound of her moonlighting experiences, she's as friendly and likable a waitress, as she is a secretary.

Judi Zimmer (left) is the Librarian. Everything to do with the Library is Judi's responsibility — ordering, cataloging, researching for members, assisting patrons, and answering telephone inquiries. Judi has been Librarian for over two years, before which she was Assistant Librarian for two years, and before that she did commission accounting work for Puritan Life Insurance Company.

Melody Zab (right) is the Assistant Librarian. She is the youngest employee, just 19 years old, and this is her first full-time job. She's only been here about one year, yet she knows her job well. (All we worry about is that a "prince" will whisk her away, since she's certainly young and pretty enough for such a thing to happen.)

Medical Meetings

MARCH 1980

						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
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APRIL 1980

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MAY 1980

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25	26	27	28	29	30	31

IARCH

Rhode Island Orthopedic Society; regular meeting; University Club, Providence
3 Pawtucket Medical Association; regular meeting
9 Rhode Island Chapter, American Academy of Pediatrics; Annual Meeting; RIMS Auditorium
5-27 New England Hospital Assembly; Hynes Auditorium, Boston
6 Rhode Island Medical Society; House of Delegates Meeting; RIMS Auditorium; 2:00 pm
6 Blue Shield Corporation; Annual Meeting; 444 Westminster Street, Providence; 5:00 pm
7 Rhode Island Dermatological Society; regular meeting; The Memorial Hospital; 8:30 pm

APRIL

Rhode Island Chapter, American Academy of Family Physicians; board meeting
1 Washington County Medical Society; business meeting
5 Allergy Foundation; meeting to form a Rhode Island Chapter; 95 Pitman Street, Providence; 7:30 pm
21 Rhode Island District Branch, American Psychiatric Association; Annual Meeting; Aboretum Restaurant, East Providence

MAY

Rhode Island Society of Internal Medicine; Annual Meeting; (May 28 tentative date)
3 Rhode Island Chapter, American Academy of Family Physicians; Annual Meeting; Rhode Island Inn, Warwick
14 Rhode Island Medical Society; Annual Meeting; Cranston Hilton; (In conjunction will be meetings of RI District Branch, American Psychiatric Association; RI Society of Pathologists; RI Chapter, American College of Physicians; RI Chapter, American Academy of Pediatrics; RI Chapter, American College of Emergency Physicians; RI Society of Allergy; RI Ophthalmological Society; joint meeting of the Providence Surgical Society and American College of Surgeons; RI Society of Nuclear Medicine; RI Otolarynogological Society)
15 Pawtucket Medical Association; Annual Meeting
17-21 Rhode Island Chapters, American College of Surgeons and American College of Physicians; joint meeting; Elbow Beach Hotel, Bermuda
24 Rhode Island Dermatological Society; regular meeting; The Memorial Hospital; 8:30 pm

* Date to be decided.

The Revising of the State Health Plan

Karen Challberg

The Statewide Health Coordinating Council is meeting weekly revising the tentative State Health Plan in line with what it learned at the public hearings held around the state in January. The next few months will decide if the public's suggestions made a constructive impression, in terms of both attitudes and specific insights to alternative measures. The fruitfulness of the public hearings as a dialogue between a planning organization and the community is yet to be seen.

Initial efforts to synthesize the public response into specific recommendations for change have been made in two proposals — one by Dr. Richard E. Carleton, Chairman of the Statewide Health Coordinating Council (SHCC), another by the staff of the State Health Planning and Development Agency (SHPDA). Various sorts of alternatives are suggested in these proposals. In some cases the changes recommended are in the wording, to remove undesirable connotations, such as the SHPDAs suggestion that the word "control" be removed wherever it appears in the section on the tactical recommendation: "All short-stay hospitals in Rhode Island should participate in uniform, centrally-monitored institutional admission scheduling and control systems." In other cases the changes suggested are numerical adjustments. For example, the SHPDA staff now recommends that by 1985 the total number of nonfederal, active patient care physicians who specialize in primary care in Rhode Island should **range** from 710 to 865, in place of the number 716 targeted in the tentative Plan. Also, the SHPDA is now recommending that the total number of nonfederal physicians providing patient care should be limited to between 165/100,000 and 200/100,000 population, in place of the tentative Plan's recommendation that there should be 159.4/100,000 population.

The following is a summary of selected recommendations from the tentative Plan, along with suggestions for revising them from the SHPDA and SHCC proposals:

Surgery

Tentative Plan Target: By 1983 the number of discharges with surgery per 1000 population in Rhode Island should be reduced by 20%.

Suggested Revision (SHPDA): By 1985, hospital discharges should be reduced by 10% . . . the proportion of all surgery performed on an ambulatory basis in 1978 should increase by five percentage points . . .

Suggested Revision (SHCC): Utilization of surgery should be the subject of continuing review by the Rhode Island PSRO . . . Ambulatory surgical facilities should be sufficiently developed to permit performance of all surgery which such review indicates can appropriately be performed without hospitalization.

Comprehensive Primary Care Services

Tentative Plan Target: By 1983 there should be at least one comprehensive primary care program operating seven days per week with 24 hour coverage per primary health service planning subarea.

Suggested Revision (SHCC): By 1985 comprehensive primary health care should be available within 10 road miles of each Rhode Island resident. (As a corollary to this recommendation, I suggest that the eighteen primary health care areas not be implemented and that they be deleted from the plan. Instead, I propose regional planning committees working with the SHCC.)

Productivity of Health Expenditures

Tentative Plan Target: Real expenditures for in-patient hospital services in Rhode Island should be reduced by 3% per annum. That is, over the next five years annual increases in in-patient hospital expenditures in Rhode Island should be 3% less than the rate of inflation in the medical care sector (i.e., the medical care price index). . . .

Suggested Revision (SHCC): Expenditures for hospital services in Rhode Island should continue to be negotiated within the context of the Prospective Budgeting Program Annual MAXICAP. Recognition both of the need for approved new programs and of the complexity/intensity of different patient care mixes, as objectively analyzed, should serve to influence the process . . . .

Total Physician Requirement

Tentative Plan Short Range Strategic Recommendation: In 1983 the total number of nonfederal physicians providing patient care should be limited to approximately 1480 (159.4 per 100,000).

Suggested Revision (SHPDA): In 1985 the ratio per population of nonfederal active patient care physicians should be between 165 per 100,000 and 200 per 100,000.

Suggested Revision (SHCC): Individual communities and hospitals should encourage high quality physicians to be active in patient care in Rhode Island in keeping with needs both for total numbers of physicians and for physician subcategories. It is estimated that the number of non-federal physicians (MD and DO) providing active patient care in 1980 is approximately 1780 or approximately 190/100,000 population and that these represent approximately the proper number of physicians to fulfill the health care needs of Rhode Island citizens. Accordingly, it is recommended that the Rhode Island Medical Society work collaboratively with the Rhode Island Department of Health, the Hospital Association of Rhode Island, the Statewide Health Coordinating Council, and with the Regional Health Services Committees to monitor the total number of physicians active in patient care in the state and in each region. Whenever that number exceeds approximately 1800 or approximately 195/100,000 population (whichever is the smaller number) on a statewide or regional basis, each health care institution within each region should encourage only needed physicians or needed physician subcategories to enter practice in that region.

Minimum Efficient Size Standards

Tentative Plan Tactical Recommendation: To the extent practical and feasible, planning, regulatory and reimbursement policies should be consistent with the following: 1. Free-standing, short-stay hospitals should have a minimum capacity of 250 beds. 2. Adult medical-surgical units should attain a minimum occupancy of 90% and have at least 100 beds. 3. Obstetrics units should attain minimum occupancy of 75% and have at least 32 beds. 4. Pediatrics units should attain a minimum occupancy of 75% and have at least 20 beds.

Suggested Revision (SHPDA): To the extent practical and feasible statewide average occupancy rates in short-stay hospitals should equal or exceed 89.4% for medical/surgical beds, 72.3% for pediatric beds, 72.5% for obstetric beds, and 89.4% for psychiatric beds . . . Free-standing hospitals should have minimum capacity of 250 beds, 32 beds for obstetrics units, 20 beds for pediatrics units, except those hospitals which serve relatively separate regions of the state (no oth hospital within ten road miles).

Suggested Revision (SHCC): To the extent practical ar feasible, planning, regulatory and reimbursement policie should be consistent with the following: a) Hospitals whic uniquely serve relatively isolated regions (no other hospit within ten road miles) should be exempted from minimum siz standards included herein. . . . b) Hospital institutions whic uniquely serve relatively isolated regions should conduct o going planning and evaluation to ensure that hospital size optimally adapted to the needs of the community serve General medical/surgical and psychiatric units should b adjusted downward to permit attainment of a minimur occupancy of approximately 88% for the metropolitan regio and approximately 85% for other regions by 1985. Pediatri and obstetrical units should be adjusted downward to perm attainment of a minimum occupancy of approximately 70% b 1985. c) Free-standing, short-stay hospitals should plan towar minimal capacity figures of approximately 200 beds, 100 bed for each medical/surgical unit, 30 beds for obstetrics units, 2 beds for pediatrics units. d) The Hospital Association and it hospital members working collaboratively with the Rhod Island Department of Health should initiate planning t achieve these goals. Such a plan should be submitted fo review and comment to the SHCC by 1 January 1982 . . . . Al levels of inter-institutional cooperation should be investigate including shared administrative services, shared professiona services, shared facilities, and ultimately, even institutiona merger.

The SHCC in meeting may accept, reject, or modify the above suggested revisions in any way it deems appropriate before chosing to take an action on any recommendation. Other suggestions for revision also may be received and considered by the Council.

The SHCC is tentatively scheduled to meet every Thursday at 5:00 pm in the Cannon Building. Dates and times may be confirmed by calling 277-3129.

■

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Rhode Island Medical Society
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Membership Goals AMA and RIMS

American Medical Association Membership last year totaled 223,000, an increase of 12,700 over the 1978 figure.

Final 1979 figures show the AMA had 192,100 dues-paying members and 30,900 dues-exempt members. Of the dues-paying total, 151,600 were regular members, 12,300 were interns and residents, and 20,200 were students.

All membership goals were exceeded last year, with regular members numbering 3,900 more than in 1978 and resident and student membership increasing 8,800 over 1978.

The Rhode Island Medical Society is also recruiting to increase its membership. Our goal is 300 new members in 1980. There are approximately 1,800 physicians licensed to practice medicine in Rhode Island. If you are a licensed physician, are you also a member of the Rhode Island Medical Society?

How To Kill an Association

Don't participate beyond paying your dues —
let "them" handle things.
Then complain that members have no voice
in management.

Decline all offices and committee
appointments — you're too busy.
Then offer vociferous advice on how
they should do things.

If appointed to a committee, don't work —
it's a courtesy appointment.
Then complain because the organization
has stagnated.

If you do attend management meetings,
don't initiate new ideas.
Then you can play "Devil's Advocate"
to those submitted by others.

Don't rush to pay your dues —
They're too high anyway.
Then complain about poor financial
management.

Don't encourage others to become members -
that's selling.
Then complain that membership is
not growing.

Don't read the mail from headquarters —
it's not important.
Then complain that you're not kept informed.

Don't volunteer your talents —
that's ego fulfillment.
Then complain that you're never asked;
never appreciated.

And, if by chance, the organization grows
in spite of your contributions
Grasp every opportunity to tell the youngsters
how tough it was; how hard you worked
in in the old days to bring the organization
to its present level of success.

(Reprinted from the *Journal of the Virginia Academy of Family Practice)*

Peripatetics

Peter L. Mathieu, Jr., MD has been appointed as the physician representative on the permanent Governor's Child Advocate Commission.

Former Rhode Island physician, **Himon Miller, MD** was recently honored by the dedication of a psychiatric unit in his honor by the Huntsville Hospital in Huntsville, Alabama.

M. Terry McEnany, MD has been named a Fellow of the American College of Chest Physicians.

Pediatrician-in-chief at Women & Infants Hospital of Rhode Island, **William Oh, MD,** is president-elect of the national Perinatal Research Society, to be installed as president of that Society in September.

Appleton Century Crofts publishers has just released a new book by **A. A. Savastano, MD,** titled *Joint Replacement Surgery.*

Representatives to the Search Board of Directors from the Rhode Island Medical Society are **Paul B. Metcalf, Jr.** and **Stanley D. Simon, MDs.**

Daniel Moore, MD has been installed as President of the Providence Medical Association. His officers are **Frank G. DeLuca, MD,** Vice President; **George N. Cooper, Jr., MD,** Secretary; **Wilson F. Utter, MD,** Treasurer; **Richard L. Testa, MD,** Councillor.

Charles Hall, J. Douglas Nisbet, Frank G. DeLuca and **Richard L. Testa, MDs** were appointed by the President of the Rhode Island Medical Society, **Charles L. Hill, MD** to comprise with him the Nominating Committee to recommend a slate of names for office in the Society, 1980-1981.

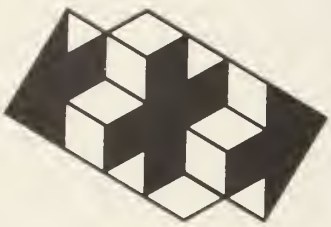
New president of the Kent County Medical Society is **James R. Hagerty, MD.**

Paul E. Barber, Richard R. Dyer, Paul J. M. Healey and Leonard S. Staudinger, MDs have been nominated to represent the Rhode Island Medical Society on the Blue Shield Board of Directors.

Note to Readers

The *Rhode Island Medical Society Newsletter* is a monthly insert publication of the *Rhode Island Medical Journal.* It's aim is to provide news of medical and health affairs in our community. Your contributions and comments are welcomed.

Peter L. Mathieu, Jr., MD, President-Elect
Karen Challberg, MA, Asst. Executive Director



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PRESIDENT'S PAGE

What Is The Rhode Island Medical Society?

What is the Rhode Island Medical Society, why should I join it, and what has it done for me? As we request extra funds added on to the already very high dues, I hear these questions more and more.

The Society is a library, a journal; a conduit for continuing education; an interface with the regulatory and political organizations; a spokesman to the public; an advocate for quality patient care. But most of all, it is people. People who have been trained in medicine, not in public speaking, politics, literary styles, advanced economics, or law. Yet, these people take time from their own academic and economic endeavors with some sacrifice to enter into these areas because someone must. Much of what these people do is not immediately visible and often a nuisance, but still must be done to maintain the interests and credibility of every physician in the state.

One should join because only in numbers may we make ourselves heard, and only in numbers may we have the money and individuals necessary to accomplish our goals.

What the Society does for you is totally dependent on what you want, and how much it is worth to you. Realistically, in view of the

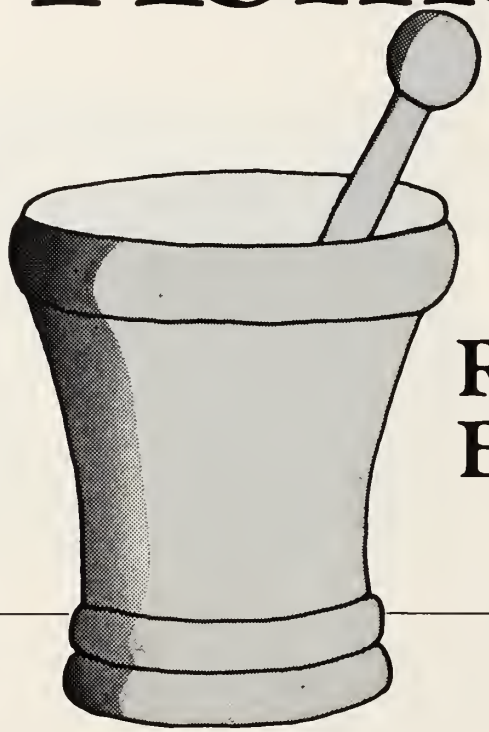
burdensome regulatory agencies demanding our attention, we should have people on our executive staff with legal training. We cannot continue to be a part-time Society. We have serious decisions to make and we need help from all of you. We need to hear your problems, and your suggestions as to possible solutions. Divide and socialize may well be the watchword of our antagonists. Let us not have to say, "We have met the enemy and he is us."

Charles L. Hill, MD ■

So, what else is new? Edit Prov Med Jour *17:11, January 1916: ". . . as if our tribute to Standard Oil was not enough when it furnishes us the motive power for our own automobiles at twenty-two cents a gallon, now we are asked to use Nujol and thus add to the income by a tax on the movement of the bowels. There will soon be a new variety of socialistic constipation." R (ogers)*

From Helen E. DeJong, Librarian Emeritus

Home Care



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DEAN'S MESSAGE

A New Approach to Continuing Medical Education

The December 1979, issue of this *Journal* amply demonstrates the extent to which continuing medical education is flourishing in Rhode Island. The many and diverse programs listed in this Calendar (fourteen pages of seminars, lectures, conferences, courses and other educational exercises) represent the cooperative efforts of the Rhode Island Medical Society, the Brown University Office of Continuing Medical Education, as well as the health care institutions and physicians of the greater Rhode Island community.

Continuing medical education assumes many formats (such as clinical demonstrations and didactic lectures), many locations (clinics, lecture halls, resort hotels) and variable numbers of participants (from audiences numbering in the hundreds to a solitary physician using audiovisual resources for self-educational purposes), and it is likely that we have neither exhausted all the possibilities nor found the one setting which will yield the best results.

The medical schools of the United States while frequently assuming a major role in continuing medical education, by providing the speakers and much of the administrative support for these programs, have characteristically distinguished between undergraduate and continuing medical education. The educational exercises conducted by medical schools for their own medical students have not been simultaneously employed for the further training of the practicing physicians (under the assumption that the educational needs, the tempo, the level of learning, the goals, and the differing backgrounds of medical students, on the one hand, and practicing physicians, on the other, are so radically different that one common educational exercise could not possibly satisfy the needs of both). And this may indeed be so. A small experiment in this direction, nevertheless, seems worthwhile.

Brown's second year of medical education is structured in an interesting manner: virtually all of the courses are organ-oriented, concerned with the fundamental pathophysiology of the organ (or system) under inquiry, and taught for a total of about 50 classroom hours

Table 1. Integrated Medical Science Courses

Field	Total classroom hours	Taught during months of
Cardiology	47	September
Nutrition	23	October
Nephrology	47	October, November
Infectious Diseases	31	November
Gastroenterology	51	November, December
Supporting Structures	36	December, January
Clinical Neurosciences	67	January, February, March
Respiratory Diseases	42	January, February
Endocrinology	52	February, March
Parasitology	17	February, March
Hematology	53	March, April
Clinical Pharmacology & Therapeutics	46	April, May
Human Growth & Development	41	April, May

extending over three or more weeks. The faculty supervising each of these courses (referred to as Integrated Medical Science modules) is multidisciplinary, and is derived from both the basic and clinical science departments. These courses are listed in Table 1.

The medical school at Brown University is now inviting applications from the practicing physicians of the greater Rhode Island community to participate, as observer-students, in one of these brief but intensive courses listed above. A faculty committee will then review all requests and choose one applicant per year for each Integrated Medical Science course with the understanding that those physicians selected for these exercises will be fully integrated into the spirit and substance of the course, fulfilling all attendance, home-study, and final examination requirements. No tuition will be charged for those invited to participate. At the conclusion of the course the physician will receive a certificate of completion noting accumulation of continuing medical education credits in Category 1 on an hour-for-hour basis.

This small effort, enthusiastically endorsed by the course leaders of these modules as well as by the University Medical Council, qualitatively departs from the conventional forms of continuing medical education and represents a frank experiment in seeking innovative ways by which the scholarly resources of the medical school at Brown University might be more effectively adapted for the continuing education needs of the physicians of this area. The very fact that the physician-participant will have to alter his office hours and will place himself in the role of a true student increases the likelihood of success in this venture.

For those participating physicians interested in applying, please write to Mrs. Irene Owens, Office of Continuing Medical Education, Box G, Brown University, Providence, Rhode Island 02912 for further information. We would also welcome your comments regarding this proposal.

Stanley M. Aronson, MD
Dean of Medicine
Brown University

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Motorcycle Helmet Law

At this writing the Rhode Island General Assembly is in session and once again will have the opportunity to consider a motorcycle helmet law introduced to replace the one that was foolishly repealed a few years ago after only a brief trial. Doctor William Q. Sturner, Chief Medical Examiner for the State of Rhode Island, who daily sees the morbid results of mayhem on the state's highways, has urged reinstitution of a helmet law.

A study by the Massachusetts Department of Public Health lends strong support for the need for such legislation. From 1966 to 1977 the number of motorcycles registered in that state increased from 36,000 to 84,500. In the same period motorcycle registrations increased nationally from 1.75 million to almost 5.0 million. Although in 1976 motorcycles comprised only 3.5 per cent of all registered vehicles in the United States, they accounted for 8 per cent of all motor vehicle fatalities. In Massachusetts in the same year motorcycles constituted 2 per cent of all registered vehicles, but accounted for 13 per cent of all fatal accidents. The death rate for motorcycle riders in 1976 was 15 deaths per 100 million miles as against 3 per cent for all other vehicles. The overwhelming majority of motorcycle deaths occur in those under 35 years of age.

With the increased use of helmets in the 1960s the case fatality rate from accidents involving head injuries dropped some 50 per cent. A California study during 1978 showed that protective headgear reduced the risk of serious head injury by 50 per cent.

Several allegations by the opponents of helmets have been proved to be without foundation.

First allegation: Motorcycle helmets, while reducing head injuries, increase the incidence of neck injuries. Unfounded.

Second allegation: Motorcycle helmets reduce peripheral vision, thus creating a hazard. Effect is actually less than 3 per cent.

Third allegation: Motorcycle helmets reduce ability to hear vehicles in traffic. Inconsequential. The noise generated by the cycle itself is so great that any reduction by the helmet is of a low order.

Fourth allegation: The weight of the helmet increases fatigue and thus causes accidents. No supporting documentation.

In 1975 a study of the effect of helmet laws in eight states indicated a decline from 10 per 10,000 registered cycles in the years before enactment to 7 per cent in the index year. Between 1976 and 1978, 27 states, including three in New England (Rhode Island is one) repealed their laws mandating the wearing of helmets. Concurrent with repeal in those states there was a sharp increase in the number of deaths from motorcycle accidents (as has occurred in Rhode Island). In Kansas, after repeal of the state's helmet law, head trauma to cyclists increased 70 per cent. The incidence of head trauma was 81 per cent higher for those not wearing helmets. The severity of head injury was 56 per cent greater and the crude death rate 310 per cent greater for drivers without helmets.

Pearl K. Russo of the Division of Preventive Medicine of the Massachusetts Department of Public Health writes: "The motorcycle has become a lethal instrument for the death and serious injury of thousands of young people each year. The medical profession can help reduce this toll by explaining the evidence to state legislators who will undoubtedly be debating bills to repeal or reinstate helmet laws over the next few years."

Let the Rhode Island General Assembly take heed!

Reference

Russo PK: Easy rider — hard facts. Motorcycle helmet laws. N Engl J Med 299:1074-1076, 4 Nov 78

International Perspective on Health Care Costs

The most recent (190th) session of the Salzburg Seminar, titled "Health Care – Allocating Resources in Urban Societies", held in the late spring of 1979 was the first to be devoted solely to a topic on health. Thirty-eight fellows and seven faculty members from seventeen nations participated. Of the seven eminent faculty members, three were from the Boston area: Sissela Bok, wife of the president of Harvard University, lecturer on Medical Ethics at Harvard Medical School, and daughter of the famed Swedish economist Gunnar Myrdal; Maurice Lazarus, Chairman of the Finance Committee of Federated Department Stores (Filene's et al); and Herbert P. Gleason, former Corporation Counsel for the City of Boston. Lazarus and Gleason were authors of a brief report of the findings appearing in a recent issue of *The New England Journal of Medicine*. The conclusions reached have special value for the United States because of the bearing they have on the debate about national health insurance. Among their observations are the following:

"European nations, eastern and western, have had long experience with the problems of health-care financing, whether by health insurance or national health service. Despite divergent approaches, all have experienced escalating expenditures, with an ever-larger share of their gross national product committed to health care – more if the national economy has been flourishing, less if it has been stagnant. Apparently, the amount of total resources allocated to health care depends more on the relative wealth of a nation than on its particular system of payment or organization.

"If Sweden, whose government owns the hospitals and employs the physicians, cannot avoid spending an ever-larger portion of its gross national product on health care, then piecemeal changes, such as consumer cost sharing, physician fee setting or even centrally budgeted national health insurance, are unlikely to control expenditures in the United States. Only a modification of demand, coupled with limits on expenditure and incentives to economize, can begin to contain the explosion in health-care costs.

"Today every force favors escalating expenditure, particularly the unrealistic expectations of consumers and the pressures to spend money for increased technology. Although such a confluence of demands is not unusual in our economy, it is often offset by constraints on spending and competition in the marketplace. In the health-care area, however, there are few checks."

Reference

Lazarus M, Gleason HP: Health care – a view from Europe, occasional notes. *N Engl J Med* 301:730-731, 27 Sep 79

The Story of Private Hospitals in Rhode Island*

Book Review

The Rhode Island Department of Health, in fulfillment of its health planning and resources development responsibilities, periodically publishes Technical Reports. The most recent of these Reports provides us with the story of the private hospitals of Rhode Island, the text of which is written by Doctor Seebert Goldowsky. The term private hospital, in this setting, applies specifically to those proprietary institutions which had operated for profit and are distinguishable therefore from those hospitals which are in the private sector but which nevertheless provide a public function. This pamphlet of some 67 pages of text, bibliography and photographs, begins with a description of the Whitmarsh Private Hospital, established in 1895, and proceeds through the present era, to the McAlpine Memorial Hospital which closed its doors in 1967 and was the last of the private hospitals

**The Story of Private Hospitals in Rhode Island*. Health Planning and Resources Development Technical Report No. 18. Rhode Island Department of Health, November 1979.

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functioning in the State of Rhode Island and Providence Plantations. The Report provides data on the size, function and life history of virtually all of the proprietary institutions of Rhode Island, some with sophisticated surgical capabilities and others which were little more than private sanitaria occasionally acting as rest homes for the alcoholic patient. It is an exceedingly comprehensive, well documented, and surprisingly interesting Report, providing the reader with a far better understanding of some of the ways in which inpatient health care delivery was rendered within this state during the last century and an important step in the evolution of our present system of hospitals.

The private hospitals of the state were most numerous in the first few decades of the current century, fulfilling in those years an identified need for middle class hospitalization. The established public hospitals of the nineteenth century were reserved principally for the poor and destitute, while the private home fulfilled the inpatient and obstetrical needs of the middle class. It was not until the Rhode Island Hospital established the Jane Frances Brown building for private patients, in 1922, that this state had comprehensive inpatient capabilities for middle class patients.

With the closing of the last proprietary hospital in 1967, the State of Rhode Island joined a small number of states which presently have no private, proprietary hospitals. Given the realities of accreditation, the mechanisms of third-party reimbursement, the monitoring of bed utilization and the enormous expense of constructing new inpatient facilities, it is not likely that we will see the reemergence of this kind of health facility. The pamphlet is worth reading to learn more about the medical history of this state during the past century.

Stanley M. Aronson, MD

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LETTERS

Ambulatory Surgery

To the Editor:

I am writing in reference to your Editorial which appeared in the October 1979 issue of the *Rhode Island Medical Journal* relating to Ambulatory Surgery.

The article stated that there were only two facilities presently existing in Rhode Island — one at Rhode Island Hospital and the other a free-standing facility in Blackstone Valley.

I would like to advise you of the facility located at Kent County Memorial Hospital which is in its fifth year of operation. During our last fiscal year we cared for 4886 patients, or a total of 15,044 since the opening of the Out Patient Surgical Unit. We have found our facility is well received by most everyone utilizing its services (patients, families, staff, physicians, etc.).

We feel the demand for this type of facility has proven itself and the potentials for this type of facility will continue to expand.

Joan Miga, RN, Head Nurse
Out Patient Surgical Unit
Kent County Memorial Hospital

The editorial in question addressed the availability of free-standing ambulatory surgical facilities with independent operating rooms, recovery rooms, and provision for general anaesthesia. The type of service described in this letter, using the main operating rooms, and in most cases with a reduced operating room charge, is available in at least five hospitals. We do not take a position as to the most cost effective method of setting up ambulatory surgical services under various circumstances, but do feel that adequate and attractive facilities generally accessible are desirable.

Ed.

A Matter of Degrees

To the Editor:

On page 463 of the November issue of the *Rhode Island Medical Journal* was printed: "In this period there were cold spells with temperatures falling to minus 20 degrees Fahrenheit (-52)." If the meaning was -52 Celsius scale, that is not correct; it should be -29 C. I really do not think that it is any significant mistake, except if repeated. With that in mind, *bona fide,* I wrote these few words.

S. Gajic, MD

Physician Owned Insurance Company

To the Editor:

I just received from the Rhode Island Medical Society a pamphlet concerning the desirability of a physicians' insurance company for malpractice coverage. I believe that we must remember that we purchase malpractice insurance to preserve our own financial stability. The great advantage of the Joint Underwriting Association (JUA) as it presently exists is that it provides for us permanent financial protection, since in the event of severe financial losses, these losses are charged to all

of the insurance companies in Rhode Island. Such protection cannot be guaranteed by any private insurance company since, if such a company should become bankrupt, doctors will become personally responsible for claims brought in the future by their patients.

An article in a recent issue of *Medical Economics* (January 7, 1980) points out that the malpractice crisis is returning. The frequency of claims and size of settlements has gone up markedly in the past two years. This means that a small insurance company, such as one with only 1,500 members in Rhode Island, would be economically unsound.

We should think very carefully before we give up the security which is provided to us under the present law which established the JUA. I hope this will be thoroughly discussed at all levels prior to any decision by the Rhode Island Medical Society.

H. Gerald Rock, MD

Discussion, review and approval by the House of Delegates will be required before the Society would be involved in the establishment of a physician owned insurance company.

Ed.

APRIL 16, 1980

1st Annual Community Pediatric Hospital Day

Kent County Memorial Hospital
Doctors' Auditorium

9:30 am
RDS Update — William Oh, MD

11:00 am
Substance Abuse in Adolescence
John Kulig, MD; Associate Professor of Pediatrics, Tufts University

12:30 — LUNCH

1:30 pm
Adolescent Sexuality — John Kulig, MD

3:00 pm
Antibiotics "1980" — George Peter, MD

Fee: $10.00, includes lunch.

Registration:
Department of Medical Education
Kent County Memorial Hospital
Tollgate Road — Warwick, RI 02886

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Brief Summary

INDICATION Tenuate and Tenuate Dospan are indicated in the management of exogenous obesity as a short term adjunct (a few weeks) in a regimen of weight reduction based on caloric restriction. The limited usefulness of agents of this class should be measured against possible risk factors inherent in their use such as those described below.

CONTRAINDICATIONS Advanced arteriosclerosis, hyperthyroidism, known hypersensitivity or idiosyncrasy to the sympathomimetic amines, glaucoma. Agitated states. Patients with a history of drug abuse. During or within 14 days following the administration of monoamine oxidase inhibitors (hypertensive crises may result).

WARNINGS If tolerance develops, the recommended dose should not be exceeded in an attempt to increase the effect; rather the drug should be discontinued. Tenuate may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle; the patient should therefore be cautioned accordingly. *Drug Dependence.* Tenuate has some chemical and pharmacologic similarities to the amphetamines and other related stimulant drugs that have been extensively abused. There have been reports of subjects becoming psychologically dependent on diethylpropion. The possibility of abuse should be kept in mind when evaluating the desirability of including a drug as part of a weight reduction program. Abuse of amphetamines and related drugs may be associated with varying degrees of psychologic dependence and social dysfunction which, in the case of certain drugs, may be severe. There are reports of patients who have increased the dosage to many times that recommended. Abrupt cessation following prolonged high dosage administration results in extreme fatigue and mental depression; changes are also noted on the sleep EEG. Manifestations of chronic intoxication with anorectic drugs include severe dermatoses, marked insomnia, irritability, hyperactivity, and personality changes. The most severe manifestation of chronic intoxications is psychosis often clinically indistinguishable from schizophrenia. *Use in Pregnancy.* Although rat and human reproductive studies have not indicated adverse effects, the use of Tenuate by women who are pregnant or may become pregnant requires that the potential benefits be weighed against the potential risks. *Use in Children.* Tenuate is not recommended for use in children under 12 years of age.

PRECAUTIONS Caution is to be exercised in prescribing Tenuate for patients with hypertension or with symptomatic cardiovascular disease, including arrhythmias. Tenuate should not be administered to patients with severe hypertension. Insulin requirements in diabetes mellitus may be altered in association with the use of Tenuate and the concomitant dietary regimen. Tenuate may decrease the hypotensive effect of guanethidine. The least amount feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdosage. Reports suggest that Tenuate may increase convulsions in some epileptics. Therefore, epileptics receiving Tenuate should be carefully monitored. Titration of dose or discontinuance of Tenuate may be necessary.

ADVERSE REACTIONS *Cardiovascular.* Palpitation, tachycardia, elevation of blood pressure, precordial pain, arrhythmia. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride. *Central Nervous System.* Overstimulation, nervousness, restlessness, dizziness, jitteriness, insomnia, anxiety, euphoria, depression, dysphoria, tremor, dyskinesia, mydriasis, drowsiness, malaise, headache, rarely psychotic episodes at recommended doses. In a few epileptics an increase in convulsive episodes has been reported. *Gastrointestinal.* Dryness of the mouth, unpleasant taste, nausea, vomiting, abdominal discomfort, diarrhea, constipation, other gastrointestinal disturbances. *Allergic.* Urticaria, rash, ecchymosis, erythema. *Endocrine.* Impotence, changes in libido, gynecomastia, menstrual upset. *Hematopoietic System.* Bone marrow depression, agranulocytosis, leukopenia. *Miscellaneous.* A variety of miscellaneous adverse reactions has been reported by physicians. These include complaints such as dyspnea, hair loss, muscle pain, dysuria, increased sweating, and polyuria.

DOSAGE AND ADMINISTRATION Tenuate (diethylpropion hydrochloride) One 25 mg. tablet three times daily, one hour before meals, and in midevening if desired to overcome night hunger. Tenuate Dospan (diethylpropion hydrochloride) controlled-release. One 75 mg. tablet daily, swallowed whole, in midmorning. Tenuate is not recommended for use in children under 12 years of age.

OVERDOSAGE: Manifestations of acute overdosage include restlessness, tremor, hyperreflexia, rapid respiration, confusion, assaultiveness, hallucinations, panic states. Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Overdose of pharmacologically similar compounds has resulted in fatal poisoning, usually terminating in convulsions and coma. Management of acute Tenuate intoxication is largely symptomatic and includes lavage and sedation with a barbiturate. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendation in this regard. Intravenous phentolamine (Regitine®) has been suggested on pharmacologic grounds for possible acute, severe hypertension, if this complicates Tenuate overdosage.

Product Information as of April, 1976

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References 1. Citations available on request from Medical Research Department, MERRELL NATIONAL LABORATORIES, Cincinnati, Ohio 45215. 2. Hoekenga, M.T., O'Dillon [Dillon], R.H., and Leyland, H.M.: A comprehensive review of diethylpropion hydrochloride. In: Central Mechanisms of Anorectic Drugs, S. Garattini and R. Samanin, Ed. New York, Raven Press, 1978, pp. 391-404.

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In uncomplicated overweight.

Many patients, on the other hand, present with excess fat but no disease. While this condition is often termed uncomplicated obesity, complications of both a social and a psychologic nature may be distressingly real for the patients. In these cases, a short-term regimen of Tenuate can help reinforce your dietary counsel during the important early weeks of an indicated weight loss program.

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For prescribing information see opposite page.

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	Darvon 65 mg propoxyphene	.66 (100)	.99 (99)	1.13 (96)	.99 (96)	.80 (96)
Statistical significance		$p<0.02$	$p<0.01$	$p<0.05$	$p<0.02$	$p<0.002$

*0 = No relief 1 = Partial relief 2 = Complete relief

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Please turn the page for a brief summary of prescribing information.

Upjohn

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Motrin® Tablets (ibuprofen, Upjohn)

Indications and Usage: Treatment of signs and symptoms of rheumatoid arthritis and osteoarthritis during acute flares and in long-term management. Safety and efficacy have not been established in Functional Class IV rheumatoid arthritis.

Relief of mild to moderate pain.

Contraindications: Individuals hypersensitive to it, or with the syndrome of nasal polyps, angioedema and bronchospastic reactivity to aspirin or other nonsteroidal anti-inflammatory agents (see WARNINGS).

Warnings: Anaphylactoid reactions have occurred in patients with aspirin hypersensitivity (see CONTRAINDICATIONS).

Peptic ulceration and gastrointestinal bleeding, sometimes severe, have been reported. Ulceration, perforation, and bleeding may end fatally. An association has not been established. Motrin should be given under close supervision to patients with a history of upper gastrointestinal tract disease, only after consulting ADVERSE REACTIONS.

In patients with active peptic ulcer and active rheumatoid arthritis, nonulcerogenic drugs, such as gold, should be tried. If Motrin must be given, the patient should be under close supervision for signs of ulcer perforation or gastrointestinal bleeding.

Precautions: Blurred and/or diminished vision, scotomata, and/or changes in color vision have been reported. If these develop, discontinue Motrin and the patient should have an ophthalmologic examination, including central visual fields.

Fluid retention and edema have been associated with Motrin; use with caution in patients with a history of cardiac decompensation.

Motrin can inhibit platelet aggregation and prolong bleeding time. Use with caution in persons with intrinsic coagulation defects and those on anticoagulant therapy.

Patients should report signs or symptoms of gastrointestinal ulceration or bleeding, blurred vision or other eye symptoms, skin rash, weight gain, or edema.

To avoid exacerbation of disease or adrenal insufficiency, patients on prolonged corticosteroid therapy should have therapy tapered slowly when Motrin is added.

Drug interactions. *Aspirin* used concomitantly may decrease Motrin blood levels. *Coumarin:* Bleeding has been reported in patients taking Motrin and coumarin.

Pregnancy and nursing mothers: Motrin should not be taken during pregnancy or by nursing mothers.

Adverse Reactions

Incidence greater than 1%

Gastrointestinal: The most frequent type of adverse reaction occurring with Motrin is gastrointestinal (4% to 16%). This includes nausea,* epigastric pain,* heartburn,* diarrhea, abdominal distress, nausea and vomiting, indigestion, constipation, abdominal cramps or pain, fullness of the GI tract (bloating and flatulence). **Central Nervous System:** Dizziness,* headache, nervousness. **Dermatologic:** Rash* (including maculopapular type), pruritus. **Special Senses:** Tinnitus. **Metabolic:** Decreased appetite, edema, fluid retention. Fluid retention generally responds promptly to drug discontinuation (see PRECAUTIONS).

*Incidence 3% to 9%.

Incidence less than 1 in 100

Gastrointestinal: Upper GI ulcer with bleeding and/or perforation, hemorrhage, melena. **Central Nervous System:** Depression, insomnia. **Dermatologic:** Vesiculobullous eruptions, urticaria, erythema multiforme. **Cardiovascular:** Congestive heart failure in patients with marginal cardiac function, elevated blood pressure. **Special Senses:** Amblyopia (see PRECAUTIONS). **Hematologic:** Leukopenia, decreased hemoglobin and hematocrit.

Causal relationship unknown

Gastrointestinal: Hepatitis, jaundice, abnormal liver function. **Central Nervous System:** Paresthesias, hallucinations, dream abnormalities. **Dermatologic:** Alopecia, Stevens-Johnson syndrome. **Special Senses:** Conjunctivitis, diplopia, optic neuritis. **Hematologic:** Hemolytic anemia, thrombocytopenia, granulocytopenia, bleeding episodes. **Allergic:** Fever, serum sickness, lupus erythematosus syndrome. **Endocrine:** Gynecomastia, hypoglycemia. **Cardiovascular:** Arrhythmias. **Renal:** Decreased creatinine clearance, polyuria, azotemia.

Overdosage: In cases of acute overdosage, the stomach should be emptied. The drug is acidic and excreted in the urine, so alkaline diuresis may be beneficial.

Dosage and Administration: Rheumatoid and osteoarthritis, including flares of chronic disease: Suggested dosage is 300, 400 or 600 mg t.i.d. or q.i.d.
Mild to moderate pain: 400 mg every 4 to 6 hours as necessary for relief of pain.

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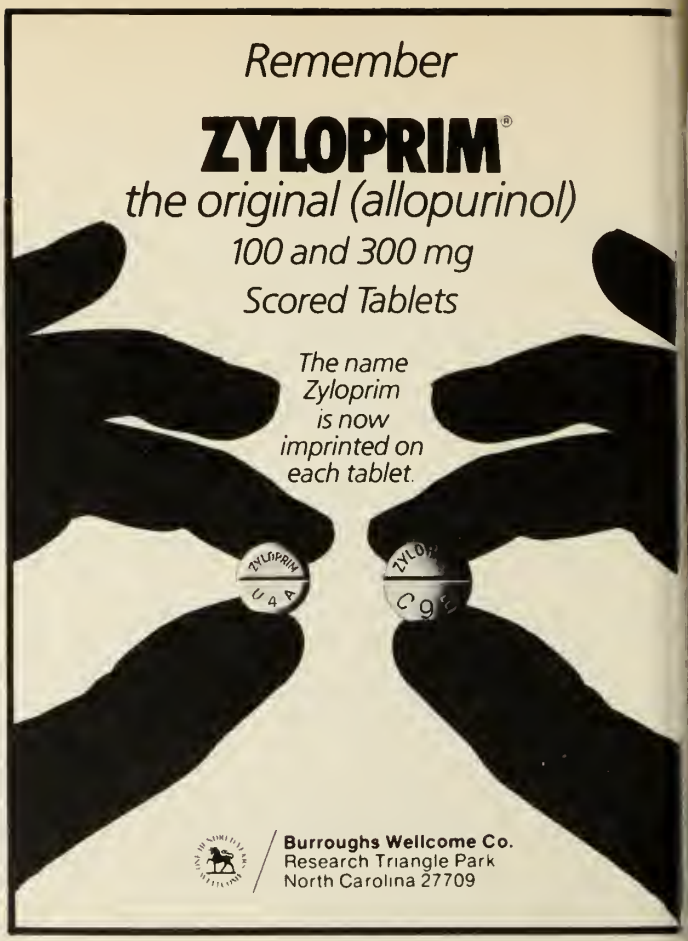

RADIOGRAPHIC CASE OF THE MONTH

For the past several years, the Department of Radiology at The Miriam Hospital has been presenting a radiologic case of the week. The purpose has been to demonstrate and explain basic radiographic signs and principles to both the house staff and attending physician. This exercise has been well received over the years. We would like to make this material available to the practicing physicians throughout the state..

Allan M. Deutsch, MD; Michael J. Ryvicker, MD; Howard Cohen, MD; Sanford Schatz, MD

Fifty year old white female with a six month history of abdominal pain and a ten pound loss.

Radiographic Findings:

Two films from an upper gastrointestinal series are presented. There is an infiltrative process with associated mass involving the pars-media lesser curvature aspect of the stomach. In addition, within the mass is a somewhat square shaped ulceration. No other abnormalities of the gastrointestinal tract were noted.

For diagnosis and discussion turn to next page.

Differential Diagnosis:
The major differential diagnosis of an infiltrative process in the stomach associated with ulcerated mass is gastric carcinoma versus gastric lymphosarcoma. Prominent rugal folds as a part of the pathological process is often necessary if one is to distinguish between the two malignancies. Multiple ulcerations and single "square shaped" ulcers are more common in gastric lymphosarcoma than in gastric carcinoma.

Diagnosis:
Gastric lymphosarcoma

Discussion:
Gastric lymphosarcoma has its origin in the aggregates of lymphocytes and lymphatic tissue in the submucosa. As the process grows it extends into the mucosa, muscularis and may extend through the serosa.

Gastric lymphosarcoma is the most common malignant lymphoma of the stomach. Involvement of the regional lymph nodes occurs in 80 per cent of the cases. In 25 per cent of the cases there are simultaneous multiple sites of involvements in the gastrointestinal tract.

There are five basic morphological types of gastric lymphosarcoma:

1. Infiltrative (18 per cent): a locally or diffusely sclerotic lesion presenting thickened, prominent rugae, sometimes with minimal superficial ulceration. This may simulate the so-called benign diffuse hyperrugosity, Menetrier's disease, or when very extensive, a scirrhous carcinoma.
2. Ulcerative (42 per cent): most commonly a localized tumor presenting as a shallow saucer-like lesion with a large ulcer and raised indurated edges. Grossly, this is often indistinguishable from carcinoma.
3. Nodular (18 per cent): a submucosal tumor often with superficial or deep ulceration. Between the nodules, the gastric rugae often appear thickened.
4. Polypoid (11 per cent): a large ulcerating mass which often perforates or extends beyond the gastric wall. It may also produce obstruction when it develops in the prepyloric area of the stomach.
5. Combined Form (11 per cent)

The radiographic features of malignant gastric lymphoma closely parallel many of the pathologic characteristics. However, they are not specific and may simulate a variety of diseases. The following radiographic findings can suggest the diagnosis:

1. Large superficial ulcer (a fungating carcinoma usually has a single ulcer, but a lymphosarcoma can have multiple ulcers.)
2. Enlarge gastric rugae associated with ulcers or polypoid masses.
3. Thickened gastric walls with loss of pliability.
4. A large tumor with little change in the contour of the stomach.
5. A smooth mucosal surface with multiple polypoid masses and ulcerations.

References

[1]Sleisinger MM, Fordtran E: Gastrointestinal Disease. Philadelphia, WB Saunders Co, 1978, pp 768-771.

[2]Marshak R, Lindver A: Gastro lymphoma. Am J Gastroenterol 66:176-184, 1976.

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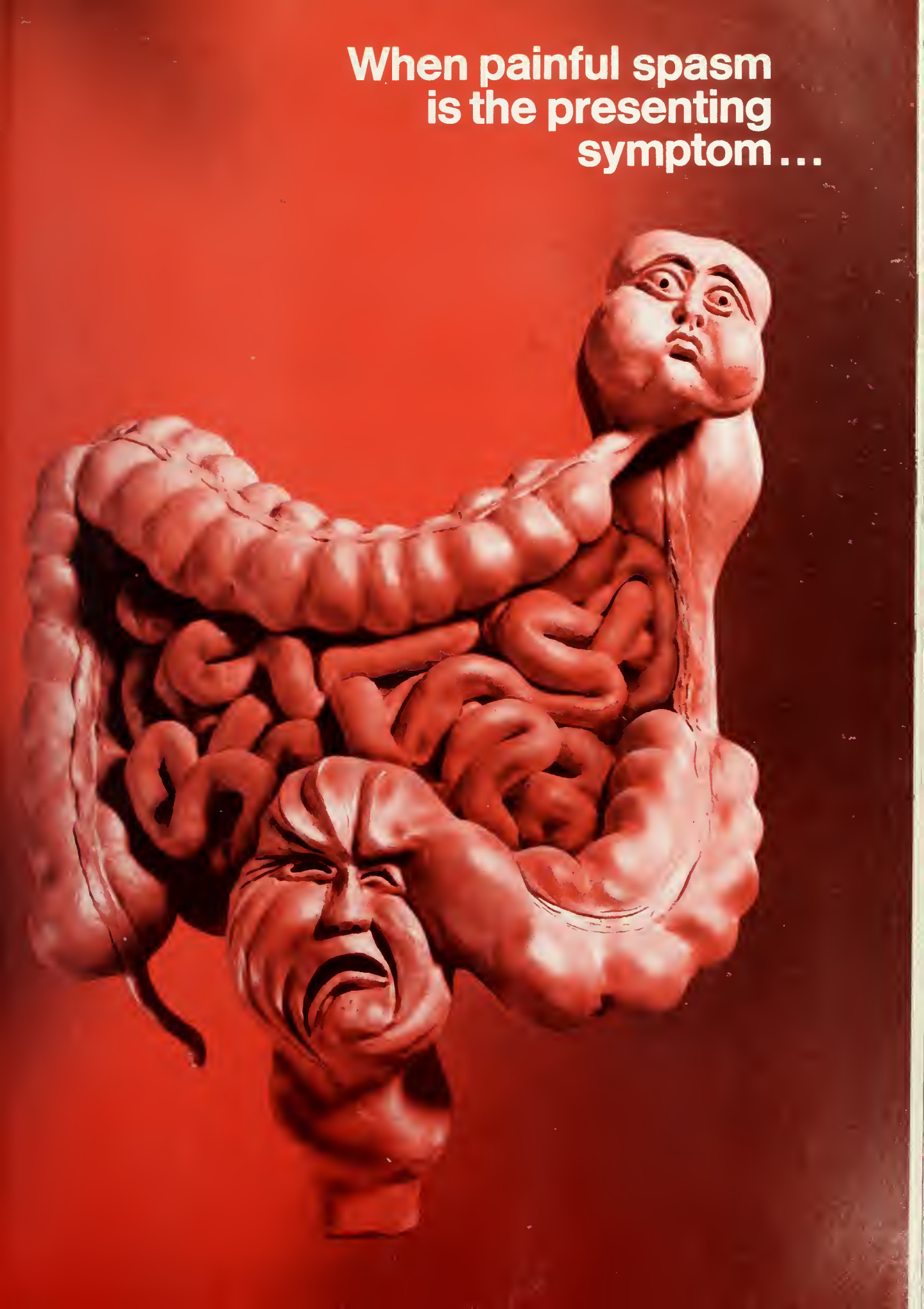

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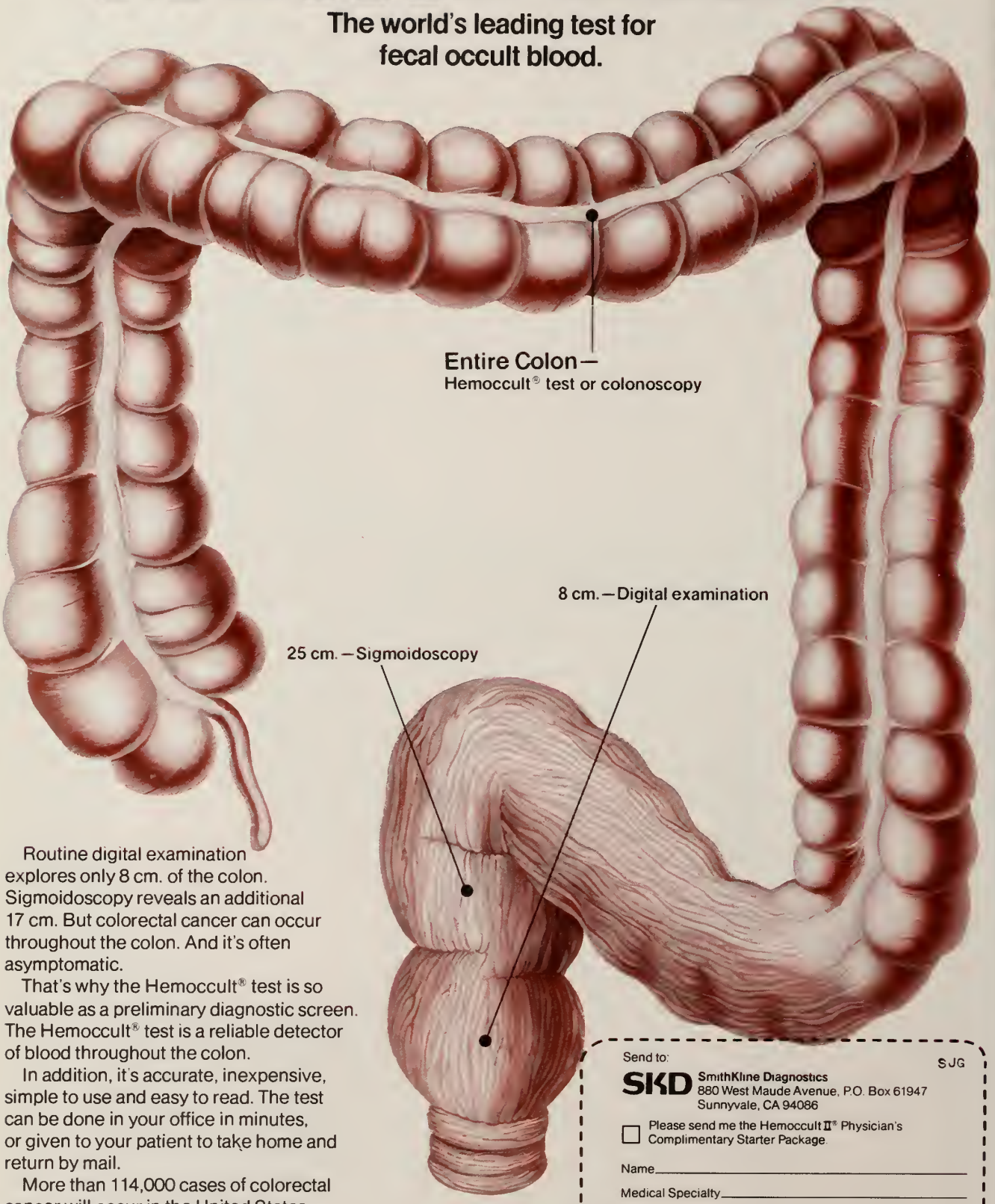

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...in the functional bowel/irritable bowel syndrome*

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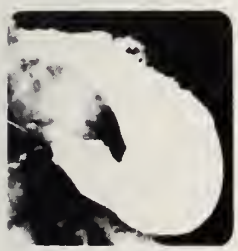
helps control abnormal motor activity
with minimal anticholinergic side effects†

Demonstrated smooth muscle relaxant activity.

In this double-blind study, twenty patients having G.I. series and exhibiting spasm were randomly selected to receive either 2 cc. of Bentyl or sodium chloride intramuscularly. Ten minutes after the injection another radiograph was taken . . .

. . . Bentyl produced definite relaxation in 8 of 10 patients. The sodium chloride produced relaxation in only 3 of 10. No side effects occurred in either group of patients.



Pylorospasm has almost totally blocked passage of barium meal.

Barium meal beginning to pass 10 minutes after intramuscular injection of 20 mg. Bentyl.

"The correlation of spasm relief and drug given was excellent."

*This drug has been classified probably effective in treating functional bowel/irritable bowel syndrome

†See Warnings, Precautions and Adverse Reactions.

See following page for prescribing information.

Reference.
King, J.C. and Starkman, N.M.: Evaluation of an antispasmodic. Double-blind evaluation to control gastrointestinal spasms occurring during radiographic examination. A preliminary report. Western Med. 5 356-358, 1964

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(dicyclomine hydrochloride USP)

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Brief Summary

INDICATIONS
Based on a review of this drug by the National Academy of Sciences–National Research Council and/or other information, FDA has classified the following indications as "probably" effective
For the treatment of functional bowel/irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis
THESE FUNCTIONAL DISORDERS ARE OFTEN RELIEVED BY VARYING COMBINATIONS OF SEDATIVE, REASSURANCE, PHYSICIAN INTEREST, AMELIORATION OF ENVIRONMENTAL FACTORS
For use in the treatment of infant colic (syrup)
Final classification of the less-than-effective indications requires further investigation

CONTRAINDICATIONS Obstructive uropathy (for example, bladder neck obstruction due to prostatic hypertrophy), obstructive disease of the gastrointestinal tract (as in achalasia, pyloroduodenal stenosis), paralytic ileus, intestinal atony of the elderly or debilitated patient, unstable cardiovascular status in acute hemorrhage, severe ulcerative colitis, toxic megacolon complicating ulcerative colitis, myasthenia gravis WARNINGS In the presence of a high environmental temperature, heat prostration can occur with drug use (fever and heat stroke due to decreased sweating) Diarrhea may be an early symptom of incomplete intestinal obstruction, especially in patients with ileostomy or colostomy In this instance treatment with this drug would be inappropriate and possibly harmful Bentyl may produce drowsiness or blurred vision In this event, the patient should be warned not to engage in activities requiring mental alertness such as operating a motor vehicle or other machinery or perform hazardous work while taking this drug PRECAUTIONS Although studies have failed to demonstrate adverse effects of dicyclomine hydrochloride in glaucoma or in patients with prostatic hypertrophy, it should be prescribed with caution in patients known to have or suspected of having glaucoma or prostatic hypertrophy Use with caution in patients with Autonomic neuropathy Hepatic or renal disease Ulcerative colitis Large doses may suppress intestinal motility to the point of producing a paralytic ileus and the use of this drug may precipitate or aggravate the serious complication of toxic megacolon Hyperthyroidism, coronary heart disease, congestive heart failure, cardiac arrhythmias, and hypertension Hiatal hernia associated with reflux esophagitis since anticholinergic drugs may aggravate this condition
Do not rely on the use of the drug in the presence of complication of biliary tract disease Investigate any tachycardia before giving anticholinergic (atropine-like) drugs since they may increase the heart rate With overdosage, a curare-like action may occur ADVERSE REACTIONS Anticholinergics/antispasmodics produce certain effects which may be physiologic or toxic depending upon the individual patient's response The physician must delineate these Adverse reactions may include xerostomia, urinary hesitancy and retention, blurred vision and tachycardia, palpitations, mydriasis, cycloplegia, increased ocular tension, loss of taste, headache, nervousness, drowsiness, weakness, dizziness, insomnia, nausea, vomiting, impotence, suppression of lactation, constipation, bloated feeling, severe allergic reaction or drug idiosyncrasies including anaphylaxis, urticaria and other dermal manifestations, some degree of mental confusion and/or excitement, especially in elderly persons, and decreased sweating With the injectable form there may be a temporary sensation of lightheadedness and occasionally local irritation DOSAGE AND ADMINISTRATION Dosage must be adjusted to individual patient's needs
Usual Dosage Bentyl 10 mg capsule and syrup *Adults* 1 or 2 capsules or teaspoonfuls syrup three or four times daily *Children* 1 capsule or teaspoonful syrup three or four times daily *Infants* ½ teaspoonful syrup three or four times daily (May be diluted with equal volume of water) Bentyl 20 mg *Adults* 1 tablet three or four times daily Bentyl Injection *Adults* 2 ml (20 mg) every four to six hours intramuscularly only NOT FOR INTRAVENOUS USE MANAGEMENT OF OVERDOSE The signs and symptoms of overdose are headache, nausea, vomiting, blurred vision, dilated pupils, hot, dry skin, dizziness, dryness of the mouth, difficulty in swallowing, CNS stimulation Treatment should consist of gastric lavage, emetics, and activated charcoal Barbiturates may be used either orally or intramuscularly for sedation but they should not be used if Bentyl with Phenobarbital has been ingested If indicated, parenteral cholinergic agents such as Urecholine® (bethanecol chloride USP) should be used
Product Information as of October, 1978

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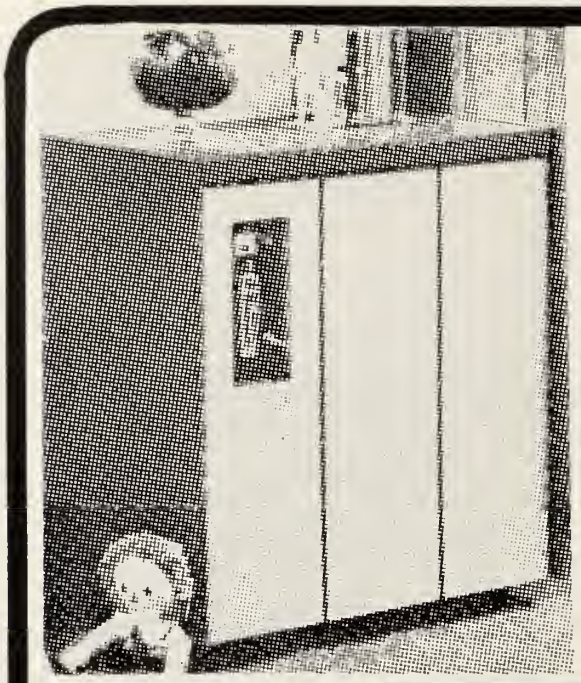

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clinical significance

of constipation

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COMPOSITION: Noturol vegetoble derivotives: A unique blend of psyllium ond senno (Plontogo Hydrocolloid with Cossio Pod Concentrote).

INDICATION: For relief of constipotion.

PATIENT WARNING: Should not be used in the presence of undiognosed obdominol poin. Frequent or prolonged use without the direction of o physicion is not recommended. Such use moy leod to loxotive dependence.

DIRECTIONS FOR USE—ADULTS: Before breokfost ond ofter the evening meal, one to two rounded teospoonfuls of Perdiem™ gronules should be ploced in the mouth ond swollowed with o full gloss of warm or cold beveroge. Perdiem™ gronules should not be chewed. After Perdiem™ tokes effect (usuolly ofter 24 hours, but possibly not before 36-48 hours): reduce the morning ond evening doses to one rounded teaspoonful. Subsequent doses should be odjusted ofter odequote loxotion is obtoined.

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FOR COLOSTOMY PATIENTS: To ensure formed stools, give one to two rounded teospoonfuls of Perdiem™ in the evening with worm liquid.

DURING PREGNANCY: Give one to two rounded teaspoonfuls each evening.

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Aspirin Intolerance Presenting as Chronic Rhinitis

Aspirin Intolerance Should Be Considered in the Diagnosis of Unexplained Rhinitis, Nasal Polyps, and Eosinophilia

Guy A. Settipane, MD

Recent surveys have indicated that aspirin intolerance occurs in 4 per cent of asthmatic patients and in 0.4 per cent of normal individuals[1]. Symptoms of aspirin intolerance are usually severe and consist mainly of acute bronchospasm or generalized hives/angioedema. However, in some cases bronchospasm may be mild and may be detected only by double blind challenge procedures, especially in asthmatic individuals who have daily low-grade pulmonary wheezing[2-4]. In rare cases, aspirin intolerance is manifested only by acute rhinitis[1]. In this report a case of aspirin intolerance presenting as chronic rhinitis is described. The unusual aspect of this case is that this patient was on practically daily aspirin medication and was unaware of any adverse reaction to aspirin.

Case Report

The patient is a 52 year old female who was referred for evaluation of persistent severe nasal stuffiness, rhinorrhea, headaches, and recurrent nasal polyps. Onset of her nasal symptoms had occurred about 5 years before at age 47. She had had a bilateral polypectomy at age 51. She also had experienced occasional slight wheezing and shortness of breath which she attributed to smoking one package of cigarettes daily for the past 37 years. She gave a history of chronic sinusitis and experienced almost daily severe headaches around her sinus areas. Because of these headaches, she was in the habit of taking 1 to 2 adult-sized aspirin tablets practically daily for about one year. At this time she was not aware of any adverse reactions to aspirin. Her nasal symptoms were on a perennial basis with no seasonal exacerbation. Past medications for her rhinitis and nasal polyps included corticosteroid (Decadron®) nasal spray, intermittent oral prednisone, and frequent decongestant tablets (Drixoral®). She had had a hysterectomy at age 48. The rest of her history was essentially non-contributory except for an allergic reaction to tetracycline. There was no family history of aspirin intolerance or nasal polyps.

Initial physical examination revealed bilateral nasal polyps. Auscultation of her lungs revealed mild generalized wheezing.

Laboratory Data. Allergy skin tests to a battery of commercial inhalant allergens (pollens, molds, and animal danders — Greer Laboratories) and selected foods were negative. Intracutaneous test to house dust (Endo Lab.) 1/4000 (wt/vol) was moderately posi-

From the Program in Medicine, Brown University, and the Division of Allergy of the Department of Medicine, Rhode Island Hospital, Providence, Rhode Island.

Guy A. Settipane, MD, Associate Clinical Professor, Brown University, Providence, Rhode Island; Physician in Charge, Division of Allergy, Department of Medicine, Rhode Island Hospital, Providence, Rhode Island.

tive. Total eosinophil count was 600, serum immunoglobulin (IgE) was 155 IU/ml, and nasal smear revealed many eosinophils (Figure I). Hemogram was normal except for a white blood cell count of 10,200 with a normal differential count. Sedimentation rate was normal. Urinalysis was normal. Serum immunoglobulins (IgG, A, M) and complement studies (CH_{100}, C'3, C'4) were normal. Blood glucose, blood urea nitrogen, creatinine, electrolytes, and alpha antitrypsin titer were essentially normal. T3 and T4 thyroid tests were normal. Chest x-ray study was normal, and sinus x-rays films revealed a pansinusitis. On initial examination pulmonary function tests revealed a peak expiratory flow rate (Wright Peak Flow Meter) of 385 L/minute which improved by 5 per cent to 405 L/minute, 10 minutes after aerosolized Isuprel.®

Because of the history of nasal polyps and almost daily aspirin intake, she was asked to discontinue all aspirin products for one week, at which time she was to be challenged with 325 mg of aspirin and a placebo on a double blind basis. After one week without aspirin her nasal symptoms were dramatically improved. At this time, auscultation revealed her lungs to be clear. One hour and 15 minutes after aspirin challenge, she developed severe rhinorrhea and frequent sneezing. She did not complain of any pulmonary symptoms, but her lungs now developed slight generalized wheezing bilaterally. Pulmonary function tests after aspirin challenge revealed a decrease in both forced vital capacity (FVC) and forced expiratory volume (FEV_1), (Table I). This decrease was reversed with aerosolized Isuprel,® which improved the FVC

Table 1. Double Blind Aspirin Challenge (325 mg).

Pulmonary Function	Placebo Challenge Pre	Post (3 hrs)	% Change	Aspirin Challenge Pre	Post (1¾ hr)	% Change
FVC (liters)	2.9	2.9	0	3.1	2.7	-12.9
FEV_1 (liters)	2.2	2.1	-4.5	2.2	1.9	-13.6
%	74	73	-1.4	73	70	- 4.1
FEF 25-75% (L/second)	1.95	1.9	-2.6	1.65	1.6	- 3.0

Table 2. Reversibility After Aerosolized Isuprel.

Pulmonary Function	Before Isuprel	After Isuprel	% Change
FVC (Liters)	2.7	3.7	+37.0
FEV_1 (Liters)	1.9	2.2	+15.8

by 37 per cent and FEV_1 in one second by 16 per cent (Table II). The rhinitis did not improve with Isuprel.® About 1 hour later she was given subcutaneous epinephrine 1/1000 (wt/vol) 0.1 ml, which promptly cleared her nasal passages. Later, after 1 week on a dye-free diet, she was challenged with 0.22 mg of tartrazine and a placebo on a double blind basis with no subjective, objective, or pulmonary function changes.

She remained on aspirin-free medication for one year, and her nasal symptoms remained much improved. She then developed a severe upper respiratory infection. Her nasal polyps significantly enlarged, necessitating a 10-day decreasing dosage of prednisone, which caused her polyps to decrease in size.

Discussion

There are two main subgroups of aspirin intolerance: the bronchospastic type and the urticarial/angioedema type. The symptom complex of acute rhinitis occurring as a result of aspirin is part of the bronchospastic type subgroup. Frequently acute rhinitis precedes the symptom of acute bronchospasm. In the present case the initial symptom of rhinitis occurred, but did not progress significantly to the bronchospastic stage. Unlike the uricarial/angioedema type, the bronchospastic type is frequently associated with nasal polyps and late age onset of aspirin intolerance[1,5,6]. This patient had nasal polyps and late age onset of aspirin intolerance. Both types of aspirin intolerance are associated with increased total eosinophil count (T E C) and normal total IgE levels[7]. This patient had an elevated T E C as well as many eosinophils in the nasal smear. However, her total IgE was slightly elevated.

The mechanism of aspirin intolerance is unknown. Immunoglobulin (IgE) or other relevant antibodies against aspirin have not

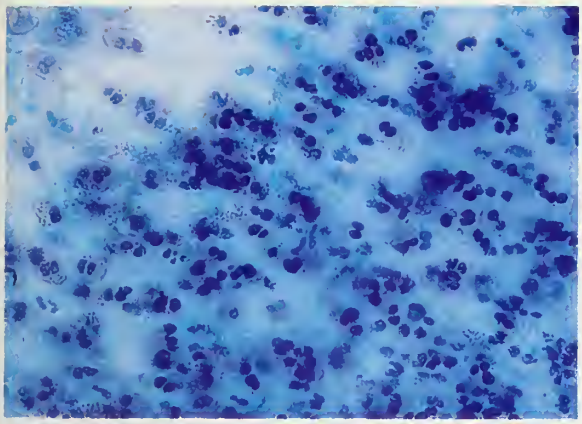

Figure 1. Nasal Smear Reveals Many Eosinophils.

Figure 2. Nasal Polyp.

been found in the sera of intolerant patients[7]. The increased total eosinophil count found in these individuals is thought to be non-specific and not related to an immunological reaction. For these reasons the term aspirin allergy has been superseded by the term aspirin intolerance.

A prevailing hypothesis for the abnormal mechanism in the bronchospastic type of aspirin intolerance holds that aspirin may affect the ratio of prostaglandin F (PGF), a bronchoconstrictor, to prostaglandin E, a bronchodilator, through its inhibiting effect on prostaglandin synthetase[1]. A predominance of PGF_2 may occur, resulting in bronchoconstriction. This hypothesis is supported by the fact that atropine inhibits the bronchoconstrictor effect of PGF_2 and also the bronchoconstrictor effect of aspirin[8]. In addition, prior treatment with cromolyn also inhibits aspirin-induced bronchospasm by preventing the degranulation and release of histamine and slow-reacting substance of anaphylaxis (SRS-A) caused by compound 48/80, a potent non-specific histamine liberator[9]. There is an association between prostaglandin and SRS-A in that both are formed from the same precursors, arachidonic acid[10]. The mediation of the bronchospastic type of aspirin intolerance may involve both the prostaglandin system and SRS-A.

Summary

A case of nasal polyps, eosinophilia, and aspirin intolerance is presented. The unusual aspect of this case is that the patient was on chronic aspirin medication and was unaware of any adverse reaction to aspirin. Most importantly, the aspirin intolerance was primarily manifested as persistent, severe rhinitis with only a mild pulmonary component.

It appears, then, that patients whose subjective complaints are chronic rhinitis of unknown etiology should also be evaluated for possible aspirin intolerance.

References

[1]Settipane GA, Chafee FH, Klein DE: Aspirin intolerance II. A prospective study in an atopic and normal population. J Allergy Clin Immunol 53:200-204, Apr 74

[2]McDonald JR, Mathison DA, Stevenson DD: Aspirin intolerance in asthma. Detection by oral challenge. J Allergy Clin Immunol 50:198-207, Oct 72

[3]Rachelefsky GS, Coulson A, Siegel SC, et al: Aspirin intolerance in chronic childhood asthma: Detected by oral challenge. Pediatrics 56:443-448, Sep 75

[4]Stenius BS, Lemola M: Hypersensitivity to acetylsalicylic acid (ASA) and tartrazine in patients with asthma. Clin Allergy 6: 119-129, Mar 76

[5]Chafee FH, Settipane GA: Aspirin intolerance: I. Frequency in an allergic population. J Allergy Clin Immunol 53:193-199, Apr 74

[6]Settipane GA, Pudupakkam RK: Aspirin intolerance III. Subtypes, familial occurrence and cross-reactivity with tartrazine. J Allergy Clin Immunol 56:215-221, Sep 75

[7]Weltman JK, Szaro RP, Settipane GA: An analysis of the role of IgE in intolerance to aspirin and tartrazine. Allergy 34:273-281, Oct 78

[8]Orehek J, Gayrard P, Grimaud C, et al: Bronchial response to inhaled prostaglandin F_2 alpha in patients with common or aspirin-sensitive asthma. J Allergy Clin Immunol 59:414-419, Jun 77

[9]Basomba A, Romar A, Pelaez A, et al: The effect of sodium cromoglycate in preventing the aspirin induced bronchospasm. Clin Allergy 6:269-275, May 76

[10]Parker CW: Prostaglandins and slow-reacting substance. J Allergy Clin Immunol 63:1-14, Jan 79

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Then...
You'll feel better in a few months, Madame. Morning sickness usually disappears after a while.
Now...
I'm glad you're feeling so well, Linda. I want you to continue the same medication.

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Brief Summary

INDICATION
Nausea and vomiting of pregnancy.

PRECAUTIONS
Because of potential drowsiness, Bendectin should be prescribed with caution for patients who must drive automobiles or operate machinery.

Studies in rats and rabbits have revealed no suggestion of drug-induced fetal abnormalities at doses of Bendectin up to 90 times the maximum human dose. In addition, several epidemiologic studies in women who received Bendectin during pregnancy have shown that the incidence of birth defects in their offspring is no higher than in women not taking the drug during pregnancy. Nevertheless, like all drugs considered for use during pregnancy, particularly during the first trimester, Bendectin should be used only when clearly needed.

ADVERSE REACTIONS
The adverse reactions that may occur are those of the individual ingredients. Doxylamine succinate may cause drowsiness, vertigo, nervousness, epigastric pain, headache, palpitation, diarrhea, disorientation, or irritability.

Pyridoxine hydrochloride is a vitamin that is generally recognized as having no adverse effects.

DOSAGE AND ADMINISTRATION
2 Bendectin tablets at bedtime. In severe cases or when nausea occurs during the day: 1 additional Bendectin tablet in the morning and another in midafternoon.

Product Information as of January, 1978

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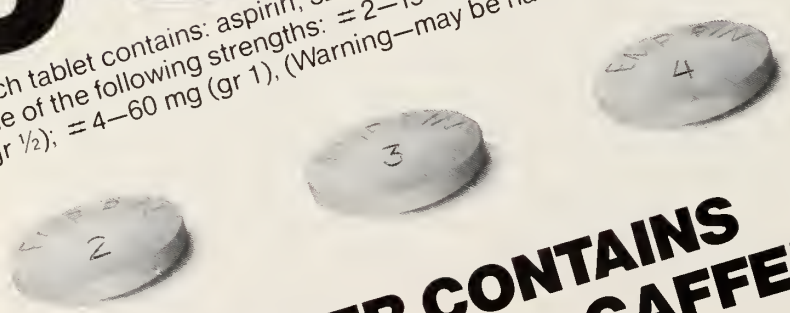

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Siegfried M. Pueschel, MD
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Clinical History

GF was born to a 26-year old primipara, blood group A, Rh—, with a negative antibody screening test. The pregnancy lasted 45 weeks (one day prior to delivery a sonogram suggested a 43 week gestation). There were no complications during pregnancy, but the mother had dental x-rays during the 18th week of gestation.

After artificial rupture of membranes, uneventful labor lasted 15 hours with clear amniotic fluid and vertex presentation. Medications included meperidine hydrochloride* and promazine hydrochloride** 5 hours and 1 hour prior to delivery. Saddle block anesthesia was administered and low forceps were applied during the 3rd stage of delivery. At birth the infant gasped, became apneic, and required immediate intubation. Apgar scores were 1 at 1 and 5 minutes. At 6 minutes epinephrine and sodium bicarbonate were injected into the heart. By 20 minutes of age the heart rate rose to 100 per minute.

Upon arrival in the special care nursery the infant was flaccid, pale, and cyanotic, and oxygen was given at 100 per cent FiO_2. The temperature was 35.8°C, heart rate 148 per minute, respiratory rate 48 per minute, blood pressure 58/42 mm Hg. Her length was 47.5 cm, the weight 2290 gm, and the head circumference 32.5 cm. The infant's features suggested 36 weeks' gestation. The anterior fontanel measured 2X2 cm, and there was a left parieto-occipital cephalohematoma. The palpebral fissures were short, the eyes deviated upward with red reflexes bilaterally, and the ears were borderline low set and posteriorly rotated with patent canals. The nares were normal. No abnormality was detected in the neck, chest, or abdomen. The umbilical cord had 3 vessels. Mild tremor-seizure activity was superimposed on an overall flaccid muscle tone. Reflexes were not easily elicited, but ankle clonus was present.

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This is one of a series of Clinical-Pathological Conferences conducted under the aegis of the Section of Pathology, Brown University Program in Medicine, Providence, Rhode Island.

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Loculated air appeared in radiographs of the left hemithorax, and a large right pneumothorax was also noted. Bilateral chest tubes were inserted and air was evacuated from the right side. Continued acidosis and respiratory difficulty were treated with sodium bicarbonate. In addition, Priscoline® and phenobarbital were given for seizures. Oxygen (100 per cent) was provided through the endotracheal tube. The mucus from the endotracheal tube was blood tinged. The blood pressure remained stable, but the patient did not void. Frequent cyanotic episodes and increasing acidosis led to bradycardia and cardiac arrest, with death at 10 hours of age.

Laboratory data are presented in Table 1.

Discussion

Dr Siegfried M Pueschel: I should like to summarize the salient features provided in the protocol. The mother, 26 years of age, gave birth to an underweight infant several weeks after term. The Apgar scores of 1 both at 1 and 5 minutes reflect severe asphyxia which required vigorous resuscitation. Subsequently, the infant developed acute respiratory distress. She had a cephalophematoma and some minor facial anomalies. Respiratory failure due to severe intrathoracic pathology finally led to the baby's death.

To discuss the differential diagnosis and to deduce the proper diagnosis, I shall dissect the case history into 5 time periods: preconceptional aspects, gestational period, delivery and immediate post partum circumstances, physical examination, and clinical course.

Preconceptional aspects focus primarily on the family and the environment. The protocol provides little such information. Were fetal wastage, stillbirths, or neonatal deaths increased in this family? Did relatives have neurological handicaps, metabolic disorders, congenital anomalies, or other inherited diseases? If some relatives had a similar disease, this surely would simplify diagnosis in this infant. If one parent were similarly affected, this would suggest an autosomal dominant condition. If consanguinity were present, an autosomal recessive disorder is more likely.

An unfavorable preconceptional environment includes occupational hazards, radiation exposures, and other mutagenic agents which lead to alterations in genes or chromosomes. Apparently, there is no such history in this family, but the importance of preconceptional information needs to be emphasized.

The second period of concern is the gestational interlude. Pregnancy was normal according to the protocol, yet some process interfered with growth, since the baby weighed 2290 grams, significantly below average.

We know of many conditions that impair fetal growth. These involve maternal, placental, or fetal factors or combinations thereof[1] and are shown in Table 2.

Let's first consider material factors. Approximately half of women with essential hypertension and secondary renal involvement deliver babies with fetal growth impairment.

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Table 1. Laboratory Data During Ten Hours of Life

Hour	Art pH	p02	pC02	BE	Other Lab Results	Oxygen Rate	Pressures	Drugs
1	6.72	14	180	−17	Dx* 90, Hct 54 Blood group, B neg			NaHC03 (15mEq total)
1½	7.11	31	38	−17		45	25/3	
3	7.32	34	17	−15	Dx* 90	40	15/2	
5½	7.07	11	45	−16	Na 143, K 5.3 Cl 95, Ca 8.8	32	15/2	Priscoline® (2mg/kg/hr) NaHC03 (5 mEq)
8	7.19	49	10	−22	Dx* 90	40	17/3	Priscoline®
10	6.9	16	34	−27	Dx* 45-90			Priscoline®

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Table 2. Conditions Associated with Intrauterine Growth Retardation

MATERNAL FACTORS	PLACENTAL FACTORS	FETAL FACTORS
Vascular disease	Twinning	Chronic intrauterine infection
—chronic hypertension		
—renal disease	Vascular & inflammatory lesions	
Metabolic disturbances		Chromosomal aberrations
—diabetes mellitus		
—adrenal insufficiency	Hemangiomata	Malformations of GI tract
Hypoxic states		
—high altitude	Placental infarction	
—cyanotic heart disease		
—hemoglobinopathies	Parabiotic transfusion syndrome	
Nutritional deficiencies		
—protein calorie malnutrition	Abnormal cord insertion	
—specific AA deficiency states		
Drugs		
—alcohol		
—smoking		
—cytotoxic agents		
Immunological influences		
—isoimmunization		
—graft vs. host disease		

Maternal diabetes mellitus, adrenal insufficiency, or other metabolic diseases may result in fetal growth retardation. Infants of diabetic mothers are usually large, but long-standing diabetes with severe vascular disease can compromise fetal growth.

Hypoxic conditions also may limit fetal growth. Living at high altitude may result in mild intrauterine growth retardation. Maternal cyanotic heart disease or hemoglobinopathies such as sickle cell disease produce more pronounced fetal growth retardation.

Nutrition during pregnancy influences the rate of fetal growth. Maternal pre-pregnant weight and weight gain during pregnancy are directly correlated with the infant's birth weight and length. Protein/calorie malnutrition also causes retarded fetal growth. So may deficiency in certain amino acids. For example, the untreated mother with phenylketonuria cannot supply sufficient tyrosine for fetal protein synthesis.

Many drugs and chemicals can cause retarded fetal growth, witness the small infants born to alcoholic mothers and to women who smoke during pregnancy[2]. Immunological factors also may compromise normal fetal growth and development, as observed in some isoimmunization disorders and graft-versus-host diseases.

Apparently our infant's mother had no pre-existing vascular diseases, metabolic disturbances, hypoxic states, or nutritional deficiencies; did not engage in alcohol consumption and smoking; nor did she take any harmful medications during pregnancy. We are told, however, that she had dental x-ray studies during the second month of gestation. Dental x-rays usually contain only fractions of one rad, they are not directed toward the abdomen, and patients are often shielded during such procedures. Furthermore, radiation this early in pregnancy is more likely to produce spontaneous abortion. The fetus is expected to be seriously affected only at levels above 50 rads[3], although any dose of radiation at a critical time can cause considerable damage in experimental situations. I doubt that the radiation received by the mother caused this infant's severe problems.

Placental abnormalities may cause fetal growth retardation. Based on correlations between fetal and placental weights, the placenta is regarded as a primary regulator of fetal growth. Twinning often results in small infants, possibly because of relative placental insufficiency. Placentas from growth retarded infants frequently have vascular and inflammatory lesions. Furthermore, hemangiomata of the placenta, extensive placental infarctions, parabiotic transfusion syndrome, and abnormal cord insertion have been associated with fetal growth retardation. The placenta was unavailable in our patient, so we do not know if any of these factors are related to her growth retardation.

Let us now consider fetal diseases. Intrauterine infections can lead to fetal growth retardation. In rubella, cytomegalic inclusion disease, herpes simplex, toxoplasmosis, and syphilis growth of the infected fetus may be impaired[4]. This infant's mother had a rubella titer of 1:20, interpreted as either previous infection or immunization. She had no prenatal illness suggesting rubella or any of the other mentioned infections. Furthermore, the infant's physical features and the clinical course are not typical for fetal infection.

Congenital gastrointestinal anomalies which interfere with fetal swallowing of amniotic fluid may produce infants who are small for gestational age, but we have no evidence for this in the case at hand.

Foremost among fetal factors that compromise fetal growth are chromosomal abnormalities. With few exceptions, eg, Klinefelter syndrome and other sex chromosomal disorders, chromosomal aberrations are associated with decreased birth weights. We studied a large population with Down Syndrome and found significantly reduced birth weights compared with normal children[5]. Growth retardation is even more severe in infants with trisomies in the D and E groups[6]. This infant probably had a chromosomal abnormality which accounts for her small size.

Let's focus on the third time period, the delivery, and the immediate postpartum circumstances. The protocol indicates that an uneventful 15 hour labor was followed by spontaneous delivery; hence, most likely no complication occurred. The mother received meperidine hydrochloride and promazine hydrochloride prior to delivery, although the doses are not provided. But then, the infant did not breathe spontaneously, nor did she respond normally to stimuli. Why did this infant display such serious respiratory distress and neurological deficits at birth? Did large doses of medication depress the central nervous system? More likely, the infant's neurologic responses were due to intrinsic problems with superimposed pulmonary pathological findings. X-ray reports mention a large right pneumothorax. Loculated air in the left chest cavity probably represents loops of bowel entering through a diaphragmatic hernia and compressing the left lung, which brings us to the fourth point of the discussion, the infant's abnormal physical findings. She was flaccid, pale, cyanotic, and in need of ventilatory assistance. She had a parieto-occipital cephalohematoma. Could there have been a linear skull fracture beneath the cephalohematoma? If so, this may have produced a subdural, or intracerebral hemorrhage, or both, since the infant's eyes were deviated upward, she had "questionable tremor-seizure activity" and was poorly responsive. Perhaps Doctor Frates can provide an explanation.

Dr Richard Frates*: The radiographs of the chest are as mentioned by Doctor Pueschel. My impression is that a left diaphragmatic hernia is present with further compromise of respiratory function by the pneumothorax on the right side. Examination of the skull shows the small left parietal hematoma, but there is no underlying skull fracture. The hypoplastic mandible has a V-shape rather than the normal U-shape when viewed in the anterior-posterior projection (Figs 1a and 1b). These findings suggest developmental defects which are basic to and preceded the problems so far discussed.

Doctor Pueschel: She also had small palpebral fissures, and her ears were posteriorly rotated and borderline low set. Only a few conditions are associated with short palpebral fissures. The fetal alcohol syndrome is one, but there is no mention of alcohol intake by the mother during pregnancy. In Down Syndrome palpebral fissures are usually short, often secondary to prominent inner epicanthal folds. Yet our infant had no other features compatible with Down Syndrome. Other syndromes with short palpebral fissures have been described due to lateral displacement of inner canthi, such as in the blepharophimosis, and Carpenter and Mohr Syndromes. Children with William Syndrome and Dubowitz Syndrome also have short palpebral fissures, but these children have normal intrauterine growth, have no diaphragmatic hernias, and otherwise have different physical features[7].

Another syndrome with short palpebral fissures also has the ear abnormalities described in this case, diaphragmatic hernias, intrauterine growth retardation, and significant difficulties at birth, and one-third of these children are born post-maturely. The

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syndrome is Trisomy 18. In addition to the characteristics described in this infant, Trisomy 18 includes occipital prominence with elongated skull, micrognathia, a prominent nasal bridge, short sternum, flexion deformities of fingers, overlapping of the second over the third and the fifth over the fourth fingers, hypoplasia of fingernails, abnormal dermatoglyphics, short dorsiflexed big toe, prominent calcaneous (rocker-bottom heel), and limited abduction of the hips. While some of these features might not have been present in the infant under discussion, the stormy clinical course probably left no time for a detailed description of the infant's physical appearance. Infants with Trisomy 18 also often have congenital heart disease, but the protocol indicates that no murmurs were heard.

Figure 1a & 1b. Examination of the skull demonstrates a small left parietal hematoma without underlying fracture. There are no intracranial calcifications. The mandible is hypo-plastic. On the anterior-posterior projection, the shape is that of a V rather than the normal U configuration.

The fifth point of my discussion deals with the infant's short life. Because of seizure activity, the infant was given phenobarbital intravenously. Seizure disorders have been reported in children with Trisomy 18, but intracranial hemorrhage or congenital abnormalities of the central nervous system could also have caused these convulsions.

Figure 2. The ependymal lining of the lateral ventricle is discontinuous. The underlying subependymal zone is poorly cellular. Hematoxylin and eosin stain. Magnification - 200X.

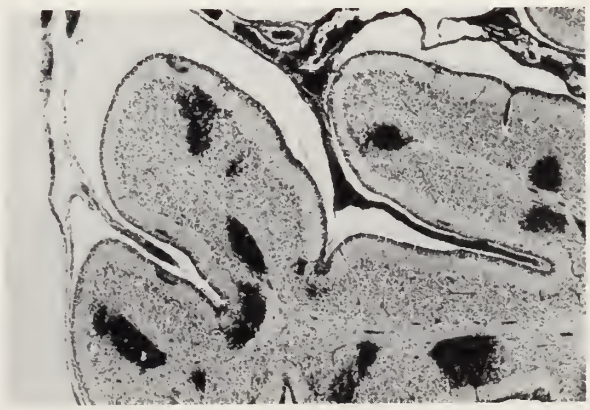

Figure 3. Photomicrograph of cerebellar folia with multiple punctate hemorrhages in cortex. These are unusually numerous in this hypoxic infant. Hematoxylin and eosin stain. Magnification - 40X.

NO urine output was recorded. Newborns sometimes don't urinate during the first 10 hours of life, but this infant most likely had a renal abnormality. Horseshoe kidneys, ectopic kidneys, hydronephrosis, and polycystic kidney disease have all been described in Trisomy 18.

As for the severe respiratory difficulties, laboratory data indicated mixed metabolic and respiratory acidosis. Treatment with sodium bicarbonate improved the acid-base balance, but frequent cyanotic episodes, increasing metabolic acidosis complicated by left diaphragmatic hernia and hypoplastic lung, and possible intracranial hemorrhage were responsible for this baby's death.

Diagnostic Considerations:

1 Trisomy 18
2 Diaphragmatic hernia
3 Right pneumothorax
4 Pulmonary hypoplasia
5 Possible CNS hemorrhage
6 Possible renal malformation

CARL A GEYER*: The medical students discussed this case earlier. Our concensus diagnoses are:

1 Asphyxia neonatorum secondary to pulmonary hypoplasia and/or agenesis
2 Diaphragmatic hernia
3 Acute renal failure secondary to polycystic kidney, or congenital malformations

Potter's Syndrome was considered because of some of the described facial features, but they were not entirely characteristic.

DOCTOR SINGER**: The external features described were again noted at autopsy. Particularly prominent were the low set ears, short palpebral fissures, and flattened nasal bridge. The nasal bones and mandible were small and maldeveloped, and the cranial fossae were also small, reflecting microcephaly (Figs 1a and 1b). The brain was reduced at least 20 per cent from the expected normal weight, but aside from mild splaying of the cerebellar hemispheres, it was not otherwise abnormal. The ependymal lining was focally ulcerated (Fig 2). Petechiae were scattered diffusely in the cerebellar white matter and folia (Fig 3). This was a striking pattern of hemorrhage, and was due to hypoxic damage.

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**Pathologist, Women & Infants Hospital, Providence, Rhode Island

The kidneys were fused at the lower poles (Fig 4). This "horseshoe" anomaly, while noted in more than 10 per cent of cases with Trisomy 18, is not life threatening[7]. The parenchyma was capable of normal function so the anuria was prerenal in origin.

Diaphragmatic hernia is a life-threatening lesion and occurs in more than 20 per cent of cases with Trisomy 18[4]. The diaphragmatic hernia here was covered by a thin membrane of muscle and fibrous tissue (Fig. 5). It was located in the left dorso-lateral area of the diaphragm, the most common site for congenital diaphragmatic hernias. This follows incomplete closure of the foramen of Bochdalek or the embryonic pleuroperitoneal canal, which usually closes at the end of the 6th week of gestation[8]. A diaphragmatic

Figure 4. Malformed kidneys with fused lower poles ("horseshoe kidney").

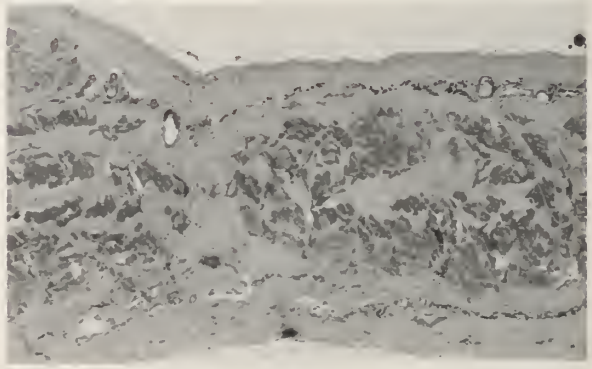

Figure 5. Photomicrograph of the diaphragm close to the edge of the hernia. Fibrosis is prominent within the muscular portion of the diaphragm. Hematoxylin and eosin stain. Magnification - 40X.

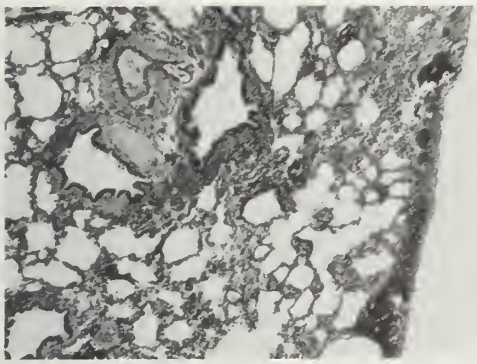

Figure 6. Photomicrograph of lung showing proximity of bronchi with cartilage in the walls to the pleural surface. This is a frequent finding in hypoplastic lungs. Hematoxylin and eosin stain. Magnification - 40X.

hernia is one of the few genuine neonatal surgical emergencies. Successful outcome depends on speedy treatment, but also on the degree of hypoplasia of the lungs. In this case, the lung on the ipsilateral side weighed 5.5 grams (expected weight 22 grams). Microscopically, features of hypoplasia were also noted (Fig 6). The shift in the mediastinum complicated matters, since this compressed the contralateral right lung, reducing its growth by 50 per cent. Pulmonary hypoplasia is surely the lethal lesion in this case and was augmented by bronchitis, bronchopneumonia, focal interstitial hemorrhage and bilateral pneumothorax.

Finally, the karyotype showed the characteristic Trisomy 18 pattern, confirming Doctor Pueschel's specific diagnosis.

Final Anatomic Diagnosis:

1 Trisomy 18, 47XX, with characteristic facial and skeletal features and microcephaly
2 Left diaphragmatic hernia (Bochdalek)
3 Hypoplastic lungs, bronchitis
4 Cerebellar petechiae
5 "Horseshoe" kidney

Acknowledgements: The autopsy was performed by Charles Neave, MD, and Stuart C. Lauchlan, MD.

References

1Behrman RE (ed): Neonatal-Perinatal Medicine: Diseases of the Fetus and Infant, ed 2. St. Louis, CV Mosby, 1977
[2]Ouellette EM, Rosett HL, Rosman NP, et al: Adverse effects on offspring of maternal alcohol abuse during pregnancy. N Engl J Med 297:528-530, 8 Sep 77
[3]Swartz HM, Reichling BA: Hazards of radiation exposure for pregnant women. JAMA 239:1907-1908, 5 May 78
[4]Warkany J: Congenital Malformations: Notes and Comments. Chicago, Year Book Medical Publishers, 1975
[5]Pueschel SM, Rothman KJ, Ogilby JD: Birth weight of children with Down's syndrome. Am J Ment Defic 80:442-445, Jan 76
[6]Hodes ME, Cole J, Palmer CG, Reed T: Clinical experience with trisomies 18 and 13. J Med Genet 15:48-60, Feb 78
[7]Smith DW: Recognizable Patterns of Human Malformations: Genetic, Embryologic, and Clinical Aspects, ed 2. Philadelphia, WB Saunders, 1976.
[8]Moore KL: The Developing Human. Philadelphia, WB Saunders, 1977. pp 149-155

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W. Martin DeLuca, PA
Clarence H. Soderberg, Jr., MD
Raymon S. Riley, MD
Patricia A. O'Shea, MD
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Case Report

E L, a 77 year old white female, was admitted to Rhode Island Hospital on December 30, 1977 with a two week history of progressive dyspnea and non-productive cough. She had presented herself to her family physician several months prior to this admission with a complaint of dyspnea on exertion. After evaluation she was placed on furosemide and digoxin for mild congestive heart failure with resolution of her symptoms.

When seen again by her physician (December 30, 1977), the patient was advised to enter the hospital for further evaluation. The patient denied chest pain, fever, chills, or palpitations.

Past medical history revealed the following: hysterectomy for menometrorrhagia 1949, tonsillectomy 1949, right nephrectomy 1969 for nephrocalcinosis, hypertension 1975 treated with thiazide diuretics, and colectomy 1976 for diverticulosis. Patient was known to have adult onset diabetes mellitus, controlled by diet.

From the Departments of Surgery (Division of Cardiovascular and Thoracic Surgery), Medicine (Division of Cardiology), and Pathology, Rhode Island Hospital, Providence, Rhode Island; and Brown University, Providence, Rhode Island.

On admission examination, pulse rate was 96 and regular, temperature 37°C, respirations 30, blood pressure 140/70. A hoarseness of the patient's voice was noted by the examiner. Increased jugular venous pressure (JVP) to 12 cm H_2O with negative Kussmaul's sign. Lungs: bibasilar rales with dullness to percussion and diminished breath

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sounds at the left base. Heart: S_1-S_2, Grade II/VI systolic murmur with an S_3 gallop. Abdomen: Obese, normoreactive bowel sounds, well healed surgical scars, no hepatosplenomegaly, no palpable tenderness or masses. Extremities: No edema or cyanosis.

Initial laboratory data revealed HB 12.1, Hct 37.6, white blood count (WBC) 8,900 with 86 per cent polymorphonuclear leukocytes, 2 band forms, 7 lymphocytes, 4 monocytes, 1 basophil. The urine was normal, EKG findings were regular sinus rhythm, rate 92, left axis, ST inverted V_3-V_6, inverted T in aV_L, and biphasic T in aV_F. Chest x-ray film (Fig 1) revealed cardiomegaly with a large left pleural effusion. Arterial blood gases on room air were pH 7.50, $pO_2$68, $pCO_2$29, and $TCO_2$23. Glucose, blood urea nitrogen (BUN), creatinine, electrolytes were 234, 21, 1.3, 143, 4.4, and 110 respectively. Enzymes were SGOT = 13, LDH = 399, CPK = 24, and alkaline phosphatase 110. Total bilirubin was 0.3.

By the morning of December 31, 1977, the patient began complaining of severe left scapular pain and remained dyspneic despite force diuresis, fluid and sodium restriction, and low flow oxygen. Subsequently, that morning a left thoracentesis was performed in which approximately 150 ml of bloody serous fluid was removed. Cell count revealed 201,798 red blood cells RBC/MM^3, 1,185 WBC/MM^3, 37 per cent polymorphonuclear leukocytes, 56 per cent lymphocytes, 3 monocytes, 4 large mononuclear cells. Cell block of this fluid revealed reactive mesothelial cells, neutrophils, and red blood cells with no evidence of malignancy. Cultures were negative.

Because of an unchanged clinical picture, cardiology and pulmonary consultations were obtained. Echocardiogram on January 6, 1978 showed no evidence of pericardial effusion or evidence of dissecting aortic aneurysm. Lung scan on January 6, 1978 indicated compressed lung tissue (left lower lobe) without evidence of pulmonary embolic disease.

Bronchoscopy on January 9, 1978 showed no evidence of intraluminal disease. Sputums for culture and sensitivities yielded fungi. Acid fast bacteria (AFB) and cytology obtained during this procedure were negative. Fluoroscopy on January 11, 1978 indicated

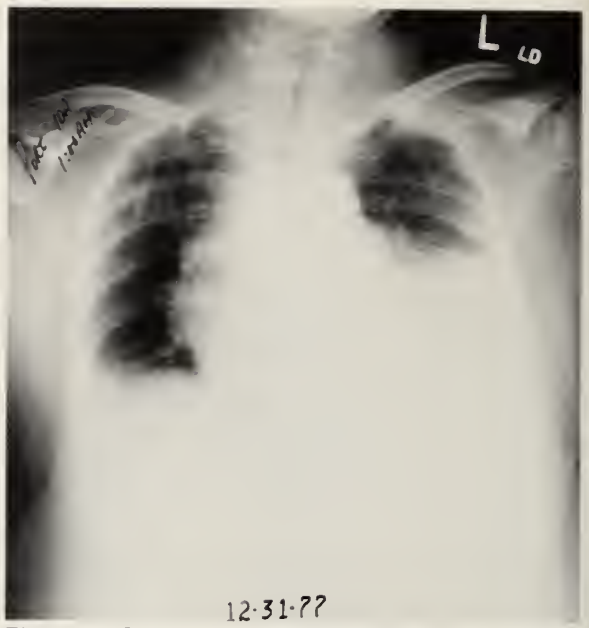

Figure 1. Chest x-ray film revealed cardiomegaly with a large left pleural effusion.

either aortic aneurysm or cardiac mass. Angiography was recommended.

Because of the refractory nature of patient's symptoms and the elusiveness of a diagnostic etiology, thoracic, abdominal and pulmonary angiography was performed on January 12, 1978, (Figs 2,3). This was interpreted as showing normal ascending aorta, left lower lung collapse with subpulmonic effusion with inversion of left hemidiaphragm, but no tumor of the left hemidiaphragm. At that juncture a thoracic surgical consultation was obtained for diagnostic thoracotomy.

On January 13, 1978 a left thoracotomy was performed (Fig 4). Upon entering the left thoracic cavity, approximately 100 ml of serosanguineous blood-tinged fluid was removed. The left lower lung was found to be grossly atelectatic and reflected cephalad, disclosing a large mass encapsulating the heart. The mass superficially resembled the pericardium and was engorged and akinetic. A careful 2 cm circumferential dissection of this mass was obtained for biopsy. Pulmonary parenchyma and diaphragm did not appear grossly involved. After the specimen was obtained, a cyst-like cavity was found. Several loculations were broken into by the examining finger espressing 150 ml of blood. The patient tolerated the procedure well and was returned to the Surgical Intensive Care Unit.

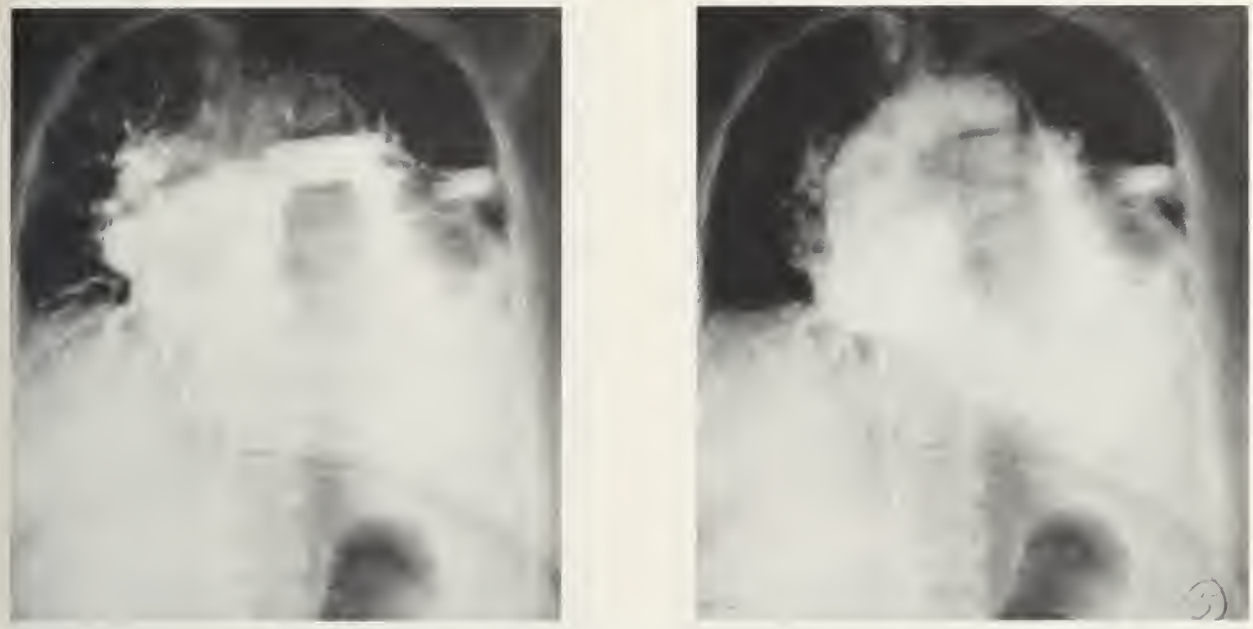

Figure 2-3. Thoracic, abdominal and pulmonary angiography was interpreted as showing normal ascending aorta, left lower lung collapse with subpulmonic effusion with inversion of the left hemidiaphragm, but no tumor of the left hemidiaphragm.

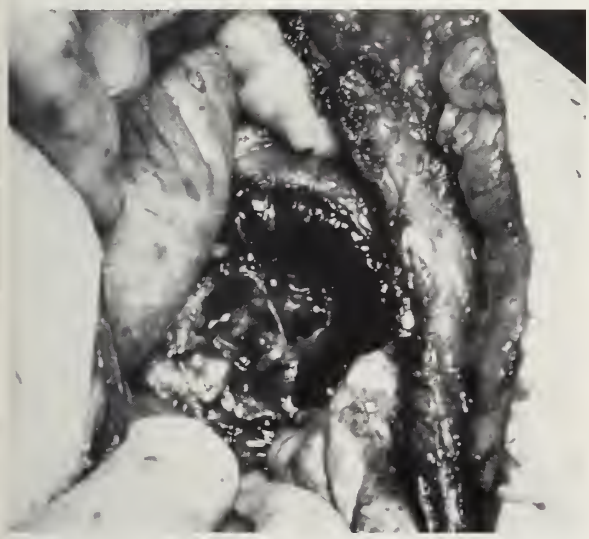

Figure 4. A left thoracotomy was performed in which the left lower lung was found to be grossly atelectatic and reflected cephalad, disclosing a large mass encapsulating the heart.

During the ensuing six days, because of respiratory insufficiency and low cardiac output, patient remained intubated and on a respirator. On January 16, 1978, the patient sustained her first of many cardiac arrhythmias and expired on January 18, 1978.

Pathologic diagnosis of the surgical specimen revealed a malignant sarcoma of presumed pericardial origin. Electron microscopic evaluation revealed rhabdomyomatous differentiation. The tumor was considered to be a rhabdomyosarcoma" (Fig 5). Necropsy on January 19, 1978 revealed no evidence of other organ involvement or tumor nidus.

Post Mortem Findings

At autopsy the heart was massively enlarged (860 grams) and almost completely encased in tumor, which was entirely confined within the parietal pericardium. There were multiple firm tan nodules on the right anterior parietal pericardium, which became confluent and involved the visceral layer toward the left postero-lateral aspect of the heart, completely obliterating the pericardial space. The greatest bulk of the tumor was adherent to the left atrium and ventricle, which measured 4 cm in thickness. The biopsy site was identified here. On cut section the tumor was yellowish-tan and somewhat nodular with many cystic areas of hemmorhage and necrosis. No invasion of myocardium could be identified.

Sections from the biopsy and the autopsy specimen revealed a sarcomatous neoplasm of rather variable morphology. The predominant pattern (Fig 6) was made up of haphazardly interlacing bundles of large spindle cells with elongated nuclei and indistinct cytoplasmic margins. No striations were seen, and there was abundant intercullar collagen.

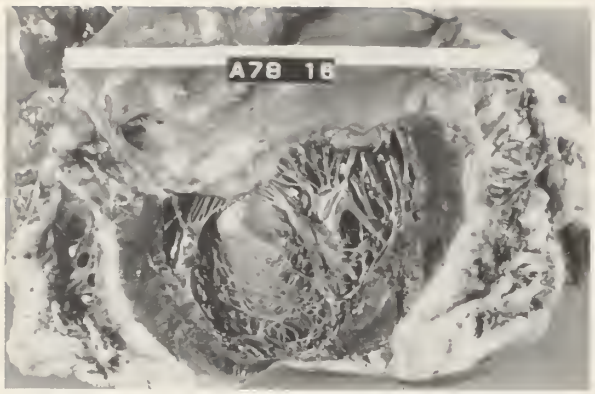

Figure 5. Electron microscopic evaluation revealed rhabdomyomatous differentiation. The tumor was considered to be rhabdomyosarcoma.

Multinucleated gland cells were present, singly and in clusters, in these areas. Occasionally, the cells were arranged in small nests very reminiscent of an aveolar pattern (Fig 7), and often they showed an epithelioid sheet-like growth pattern in which the cells appeared rounded or ovoid with more visible cytoplasm (Fig 8). In the latter areas, there was a marked degree of anaplasia and pleomorphism due to large bizarre, frequently multinucleate cells and strikingly abnormal mitosis (Fig 9). In all areas the mititic rate was extremely high, and there were large areas of necrosis. Extensive sampling demonstrated clearly that the tumor was confined to the pericardium and nowhere involved the myocardium.

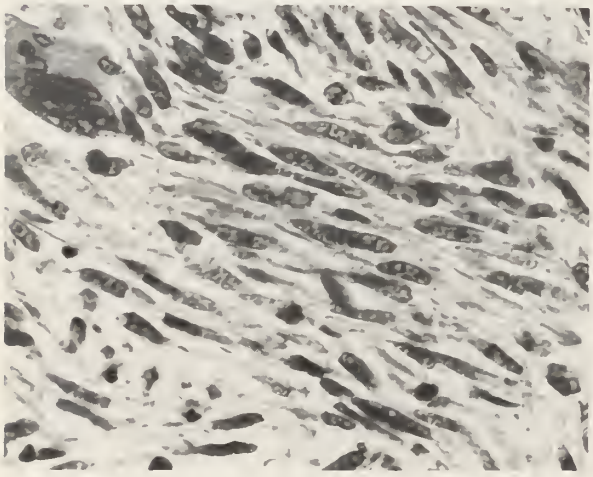

Figure 6. Section from the biopsy and the autopsy specimen: pattern of haphazardly interlacing bundles of large spindle cells with elongated nuclei and indistinct cytoplasmic margins.

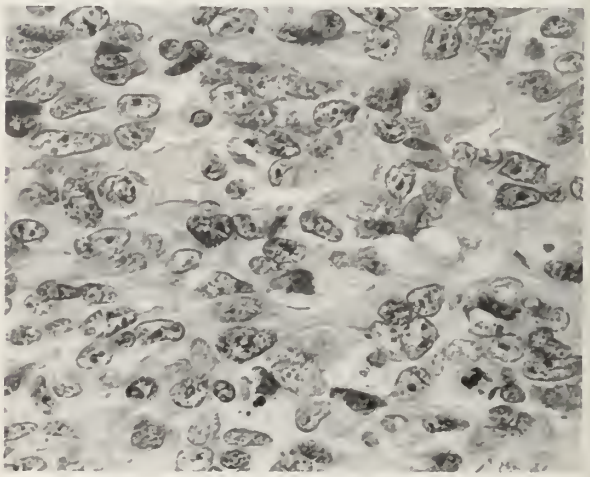

Figure 8. Section from the biopsy and the autopsy specimen: epithelioid sheet-like growth pattern with the cells rounded or ovoid with visible cytoplasm.

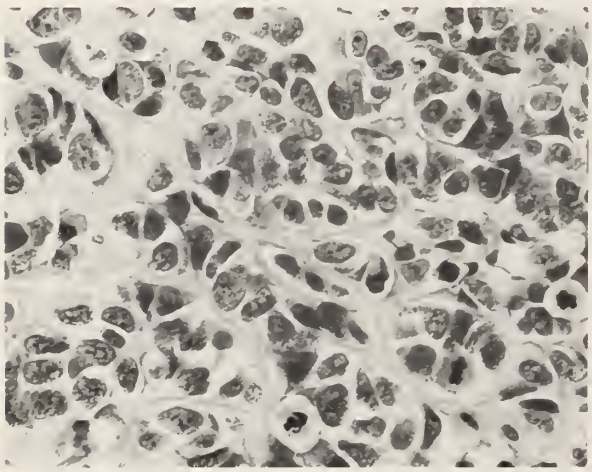

Figure 7. Section from the biopsy and the autopsy specimen: arrangement of the cells in small nests very reminiscent of an aveolar pattern.

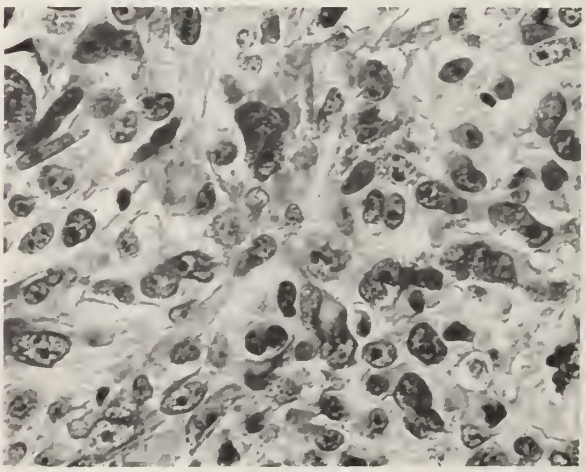

Figure 9. Section from the biopsy and the autopsy specimen: large, bizarre, frequently multinucleate cells.

Ultrastructural studies of the surgical biopsy revealed embryonal rhabdomyoblastic parallel myofibrils with abortive 2-band formation.

The rest of the postmortem examination showed only stigmata of chronic congestive heart failure and shock, ie chronic passive congestion of the lungs and acute tubular necrosis.

A review of the literature reveals that the incidence of primary heart neoplasms is 0.002 per cent, of which 25 per cent are malignant.[1] Primary malignant tumors of the heart are almost invariably sarcomas with rhabdomyosarcomas being the most common. Myocardial sarcomas are usually situated in the right atrium, where they interfere with valve function.[2] The clinical course is characterized by a sudden onset of right ventricular failure.[3]

The present case of rhabdomyosarcoma is unusual in that it arises from the pericardium adjacent to the left atrium and ventricle and does not involve the myocardium. This patient presented, as do most patients with pericardial tumors, with shortness of breath, chest pain, dyspnea, a non-productive cough, and refractory heart failure.[4]

Additional autopsy findings included mild bilateral bronchopneumonia, mild hepatic fatty metamorphosis, diverticulosis coli, and mild hydronephrosis of the left kidney.

Death was due to refractory congestive heart failure and cardiogenic shock secondary to an encapsulating pericardial rhabdomyosarcoma.

Summary

A case of rhabdomyosarcoma of the pericardium is reported. Origin in the pericardium without involvement of the myocardium is rare.[5-7]

References

[1]Kennedy FB: Primary leiomyosarcoma of the heart. *Cancer* 20:2008-2012, Nov 67.
[2]Sherman M, Notman J, Schmroth L: Metastatic rhabdomyosarcoma of the heart. Heart Lung 5:127-130, Jan-Feb 76
[3]O'Reilly MV, McDonald RT, Fornaisier VL: Clinical presentation of the myocardial rhabdomyosarcoma. Br Heart J 37:672-675, Jun 75
[4]Pader E, Kirschner PA: Primary sarcoma of the pericardium. Amer J Cardiol 14:399-406
[5]Shin MS: Pericardial mesothelioma masquerading as rheumatic heart disease, editorial. Arch Intern Med 137:257, Feb 77
[6]Osmond GS, Knight L, Dehner LP, et al: Alveolar rhabdomyosarcoma involving the heart. Circ 54:837-43, Nov 76
[7]Eldor A, et al: Alveolar rhabdomyosarcoma presenting as subacute intravascular coagulation. J Clin Pathol 30:661-665, Jul 77

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NEWSLETTER

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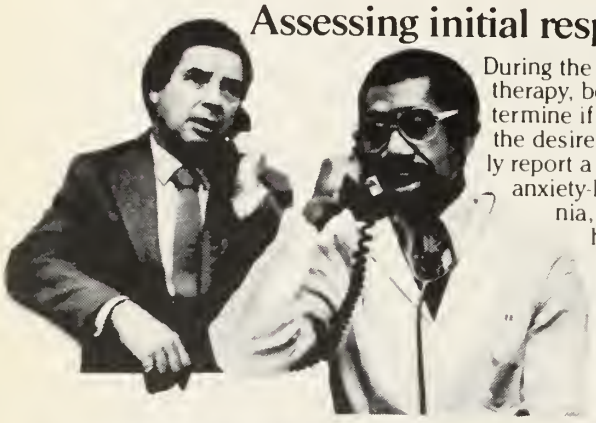
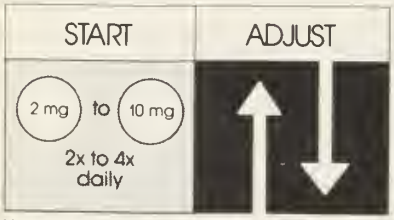
Monitoring patient response to Valium® (diazepam/Roche)



Assessing initial response to therapy

During the first follow-up visit after initiating therapy, both physician and patient should determine if Valium (diazepam/Roche) is having the desired effect. Most patients will promptly report a feeling of relaxation and relief of anxiety-linked symptoms such as insomnia, headaches, palpitations and hyperventilation. You will probably observe that the patient is calmer and more relaxed. If, however, patient response does not measure up to expectations, a reevaluation of the patient's profile with modification of the dosage regimen should be considered.

Making dosage adjustments



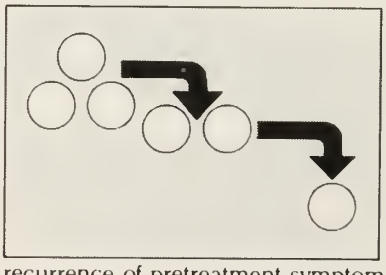
With any psychoactive medication it is good medical practice to initiate therapy at base dosage levels and titrate to the patient's needs. With Valium, experience has shown that 5 mg t.i.d. is usually sufficient although some patients with severe or persistent anxiety may require higher dosages initially. In geriatric or debilitated patients, the recommended dosage is 2 to 2½ mg once or twice daily. When anxiety fluctuates, as is common with most patients, the dosage may be adjusted as needed during the course of therapy; three strengths in scored tablets give you unmatched flexibility and simplicity in individualizing dosage.

Evaluating progress toward therapeutic goals

SET GOALS						
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	31		

At the beginning of therapy it is now common practice for both physician and patient to establish treatment goals and to estimate the amount of time needed to achieve them. Then the patient knows what to expect and when to expect it. Some physicians find that compiling a checklist of presenting symptoms and complaints is useful for assessing the patient's response from visit to visit. In this way, progress toward attainment of the therapeutic goal is reviewed at regular intervals. As patients feel their symptoms abate and begin to develop insight into the sources of their anxiety and psychic tension, the checklist can be expected to dwindle.

Discontinuing pharmacologic intervention



When you decide to discontinue therapy, tapering dosage is good medical practice. Although rarely necessary after short-term treatment with Valium, gradual dosage reduction is advisable for patients who have been on extended therapy. This gradual discontinuance should preclude either recurrence of pretreatment symptoms or development of untoward side effects. Symptoms of withdrawal have almost always been associated with abrupt discontinuance of therapy at higher dosages taken continuously over long periods of time.

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The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma, may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice, periodic blood counts and liver function tests advisable during long-term therapy.

Dosage: Individualize for maximum beneficial effect. *Adults.* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d. alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

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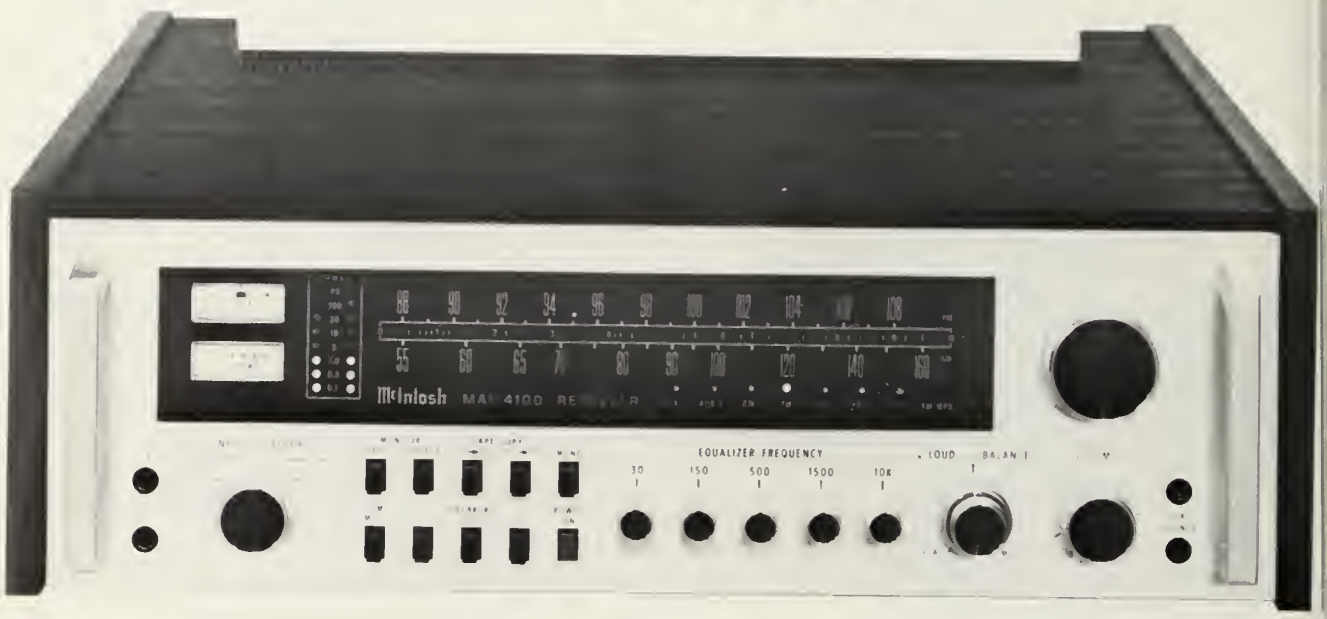

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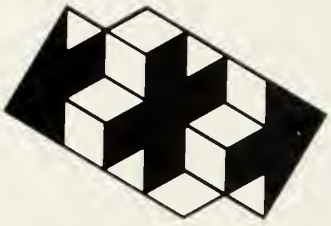
COVER

Two Beings (1899): This print by the Norwegian artist Edvard Munch was originally done in two colors from one wood block in two pieces. In this work as in many pieces by Munch the images suggest human separation and anxiety, and the mood is sad.



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Council Briefs

Meeting March 10, 1980
Charles L. Hill, MD, Presiding

- Heard reports from attendees of the national AMA Leadership Conference held in Chicago, February 21-24.
- Heard a report from the President on negotiations with the Department of Health toward improvement of the health planning process, particularly by establishing better mechanisms for regional representation.
- Discussed ideas for Rhode Island Medical Society sponsored continuing medical education programs.
- Acknowledged and expressed appreciation to Drs. Edmund T. Hackman, James A. McGrath, and Melvyn M. Gelch for their contributions to the Council. This is the last meeting of their terms.
- Heard remarks on the feasibility of a physician-owned company in Rhode Island, which has been studied by Johnson & Higgins, and also on the possibility of the Rhode Island Medical Society becoming a broker for the Joint Underwriting Association.
- Heard a report from Dr. Peter L. Mathieu, Jr. on public laws activities, followed by discussion.
- Recommended an annual dues increase of $25 for 1981. The recommendation will be presented to the House of Delegates at its meeting in September.
- Heard a report of the Treasurer, Dr. Melvyn M. Gelch.
- Heard a report of Dr. Herbert E. Hager, Chairman, Committee on Standards and Credentials, on the compliance with the CME requirement for relicensure.
- Considered the report of the Subcommittee on Nominations. A motion was passed that the Subcommittee reconvene. A motion was passed that there should be one student and one resident member on each committee. A motion was passed that the nominations list should incorporate asterisks to designate those who are AMA members.
- Passed a motion that a request to discuss the Blues Major Medical coverage versus commercial major medical coverage be referred to the Medical Economics Committee.
- Passed a motion that the President of the Rhode Island Medical Society appoint a committee to study the organization's administrative staff structure.
- Passed a motion to recommend that the Rhode Island Medical Society's Council and Delegates support Dr. H. Thomas Ballantine, Jr., of Massachusetts for President-Elect of the American Medical Association in July 1980.

Legislative Roundup

Howard E. Lawton

The Public Laws Committee under the chairmanship of Dr. Peter L. Mathieu, Jr. and co-chairmanship of Dr. Peter D.T. Clarisse has been meeting every three weeks during this legislative session. Over fifty (50) bills have been reviewed by the committee and several more just introduced will be screened by the committee.

The Public Laws Committee, on behalf of the physicians of the Rhode Island Medical Society, has had the following bills introduced:

S-2737 (Gendron) — A bill modifying the definition of a clinical laboratory as it relates to a doctor's office.

S-2651 S-2723 (Gendron) — A bill changing from January to October the date for submission of verification of continuing medical education and authorizing waiver of education requirements on an individual basis for just cause. This is actually two bills for the same purpose, one applying to MD's, the other to DO's.

H-7767 (Freda, Skeffington) — A bill incorporating the Medical Mutual Insurance Company of Rhode Island to underwrite casualty and other insurance. This is the Charter Bill voted by the House of Delegates to obtain a Charter for a physician-owned insurance company.

H-7594 (Freda, Skeffington) — A bill setting up a 24-hour hot line between the general assembly and the Rhode Island Medical Society so that legislators may present their concerns directly to the Society, discuss certain issues prior to the introduction of a bill, etc.

A hearing was held on Bill H-7172 at which Attorney Charles Butterfield and Howard Lawton testified before the House Committee on Corporations and explained the Rhode Island Medical Society position. This is the bill that prohibits a physician from refusing treatment to any person who has funds to pay for treatment forthwith.

A hearing was held on Bill S-2300 before the Senate Committee on Judiciary at which Dr. Milton Hamolsky testified and greatly impressed the audience by his erudite presentation on this issue. This bill relates to the requirement of informed consent in cases of abortion.

Representative Al Cardente prepared for introduction a bill which would require anesthesiologists participating in a non-profit medical service to accept the fee paid under the plan as full compensation for their services, but will withhold the bill following a meeting with one of Mr. Cardente's constituents (who had raised the complaints), Dr. Charles L. Hill, Dr. Augustine M. McNamee, Jim Clarkin and Howard E. Lawton.

A "house call" at the request of Dr. Herbert F. Hager was made by Howard Lawton to Dr. Hager's office to explain the Public Laws Committee and the way the various bills are introduced and handled. Dr. Hager had two new doctors, Jeffrey H. Drogin and Anthony V. Rocha, who are greatly interested in legislative matters, present for this presentation.

Newport County Medical Society Report of Meeting

At a dinner meeting on March 5, 1980, James Dy, President of Medserco, current administrators and ganizers of the successful St. Louis, Missouri Me Health Plan (IPA) spoke to some 40 members of t Newport County Medical Society and invited rep sentatives of the Newport Hospital Administration a Board of Trustees.

The evolvement of the IPA concept, the running the program in St. Louis and the benefits of a simil situation here in Rhode Island were discussed. It w pointed out that there are positive political as well economic considerations involved in such an arrang ment. An IPA can deliver quality health care at a re sonable cost to a large percentage of people. A gener explanation and discussion then followed of the Ocea State Health Plan—the state-wide IPA that is current being proposed for Rhode Island.

The advantages of the IPA include preserving the fe for-service concept, accomodating all types of medic practices (from solo to the large multi-specialty group affording the patient free choice of affiliated phys cians, paying in full for all medically related expense whether for inpatient or outpatient care, paying for pr ventive as well as therapeutic services, and eliminatin accounts receivable, patient billing and costly pape work.

Ocean State Master Health Plan policy and pr cedures will be geared to optimal cost-effectiveness i the utilization of services, in the structure of charge for services, and in the administration of the syster Such processes as ambulatory peer review, preadmi sion testing, a hospital certification program, a phys cian committee to review fees and charges, physicia and patient education, and computerized administra tion will be used to achieve these goals.

In the question and answer session of the meetin much interest was expressed in the overall concept.

Peter D.T. Clarisse, MD, President
Stephen N. Grimes, MD, Secretary

Federal Folly Facts and Figures . . .

According to US Chamber of Commerce President Richard L. Lesher, in 1980 the average American will have to work the equivalent of nearly *five months* to pay his taxes.

The average share of the national debt, and other obligations already run up by the federal government, has now reached *$46,000 per person.*

According to a *10-year, $60 million* federal study in Seattle and Denver, people who have guaranteed annual incomes are less likely to work.

(Reprinted from the newsletter publication of the Indiana State Medical Association)

Echocardiography Today

Barat B. Vibhakar, MD

Since its inception, the understanding and usage of echocardiography has grown by leaps and bounds. It has completely revolutionalized the approach to a cardiovascular problem, be it acquired or congenital. Its application has made cardiovascular anatomy quite simple and easy to understand. The cardiac structures are visualized with greater depth and the pathophysiology is understood more precisely by everyone involved in the practice of medicine, including research.

Many cardiac conditions once were difficult to be recognized in the clinical practice without submitting the patient to elaborate invasive procedures. Today, a cardiologist feels quite at ease in his office to make a definitive diagnosis of conditions like mitral valve prolapse, cardiomyopathies, cardiac asynergies, aneurysm and a rarer condition like left atrial myxoma. With the advent of health care and antibiotics, rheumatic heart diseases have become a rarity. However, one occasionally sees a case of mitral and artic valve disease which had gone unrecognized in the past or new cases are seen amongst the migrant population. With the help of echocardiography, these are conditions are diagnosed and further recommendations are outlined in the office. Rarely infective processes like vegetations on the valves or pericarditis and effusion are also easily recognized. Also, malfunction of prosthetic valves can be documented without much difficulty.

The understanding of a more common condition like coronary artery disease by echocardiography has helped in proper management of these patients. Varieties of pathology, anywhere from ischemic heart disease to aneurysm and rupture of subvalvar apparatus like chordie tendinae or interventricular septum, are recognized. In a patient with myocardial infarction, long term follow up has become more precise as echocardiography entails the nature of the disease process together with the functional capacity of the ventricle. Importantly, amongst hypertensive patients, documentation of cardiac involvement is quite mandatory and early muscle hypertrophy or chamber dilatation are recognized quite precisely by echocardiography. Also, dissection of the aortic root in some of these patients can be diagnosed at the bedside and urgent treatment can be outlined at its earliest. Congenital cardiac malformations have been understood well and earlier in life by echocardiography. On several occasions, it has helped eliminate unnecessary invasive cardiac studies in children. Conversely, it has helped one to be more aggressive in taking care of a sick child with conditions like hypoplastic left ventricle, severe pulmonic stenosis, and cyanotic Fallot's tetralogy.

Thus, it can be seen that at every stage of life, echocardiography helps clinicians arrive at a diagnosis which would, under ordinary circumstances, not be possible and also helps a patient get the advantage of early diagnosis and treatment. As the pioneer of echocardiography, Dr. Harvey Feigunbaum, says, "The rise in popularity is not only because the technique is non-invasive and offers no hazard to the patient, but also because the examination provides information which is unique and is not available with any other test".

5TH WILLIAM P. BUFFUM ORATION

REBECCA H. BUCKLEY, M.D.

Prof. of Pediatrics, Duke Univ., Durham, N.C.
President, American Academy of Allergy

WILL SPEAK ON . . .

"IMMUNODEFICIENCIES - A Clinical Approach"

SAT., MAY 3, 1980 - 10 a.m. - 12 Noon

GEORGE BUILDING AUDITORIUM
RHODE ISLAND HOSPITAL

Providence Medical Association Auxiliary

is sponsoring

A NIGHT AT TRINITY

MAY 4, 1980

Contact: **JERI AZZOLI**
255 Stone Ridge Dr., East Greenwich, RI 02818
Tel: 885-1884

— *SHCC Dates* —

In preparation for a final ballot on May 5th on the revised State Health Plan, the Statewide Health Coordinating has scheduled the following:

April 17: meeting 3:00 - 9:00 pm
SHCC Meeting Room

April 21: public hearing 7:00 pm
RI Department of Health Auditorium

April 24: meeting 3:00 - 9:00 pm
SHCC Meeting Room

Impaired Physicians Program

The Rhode Island Medical Society Impaired Physicians Program is now operational. If you desire more information concerning this program, if you know an impaired colleague who needs help, or if you are concerned about yourself or your spouse, please contact the Executive Director at the RIMS Executive Office. All such contacts will be held in strictest confidence and the caller need not reveal his name, if he/she so desires. When contacted by the Chairman of the Committee on the Impaired Physician, identification is required to confirm the validity of the call. This again will be held in strictest confidence.

Alcoholism, other drug abuse, and medical/neurological/psychological problems are potentially treatable conditions. All impaired physicians should be encouraged to seek help at the earliest possible time in order to retain or regain full effectiveness to practice medicine.

New President of Providence Medical Association Daniel Moore, Jr., MD

Dr. Daniel Moore, Jr., was installed March 5, 1980 as the President of the Providence Medical Association at that organization's 133rd Annual Meeting at the Cranston Hilton Inn. Dr. Moore, who is a graduate of Brown University and Tufts Medical School, is a practicing cardiologist. He has been active in the Providence Medical Association and the Rhode Island Medical Society for years, recently as a member of the state society's Council, its highest advisory body.

Other new officers are Dr. Frank G. DeLuca, Vice President, Dr. George N. Cooper, Jr., Secretary, and Dr. Wilson F. Utter, Treasurer. This year's delegates from the Providence Medical Association to the Rhode Island Medical Society are Drs. Charles J. Ashworth, Jr., Michael S. Barrett, Joseph P. Bellino, Bernard J. Berstein, Thomas G. Breslin, Alphonse R. Cardi, Erminio Cardi, Robert F. Caspari, Frances P. Conklin, George N. Cooper, Jr., John J. Coughlin, Frank G. DeLuca, John E. Farley, Jr., Herbert F. Hager, Melvin D. Hoffman, Harry M. Iannotti, Robert A. Indeglia, Jerry M. Kheradi, William S. Klutz, Mary D. Lekas, Joseph P. Lombardozzi, Betty B. Mathieu, Richard T. McDermott, H. Raymond McKendall, Anthony F. Merlino, Julius C. Migliori, Daniel Moore, Jr., Herbert Rakatansky, Robert W. Riemer, Barbara H. Roberts, Robert G. Rosenberg, Guy A. Settipane, Rajnikant K. Shah, Louis V. Sorrentino, Hugo Taussig, Richard L. Testa, Joseph R. Tucci, Louis Vito, Jr., Raymond W. Waggoner, Jr. Representatives from the Providence Medical Association to the Rhode Island Medical Society Council are Dr. Richard L. Testa, Councillor, and Dr. Frank G. DeLuca, Alternate Councillor.

Installed for three-year terms as members of the Providence Medical Association Executive Committe were Drs. Maurice M. Albala, Milton W. Hamolsk Herbert Rakatansky, and Louis Vito, Jr., and re-installe as Trustee of the Rhode Island Medical Library from th Providence Medical Associaiton for a one-year ter was Dr. Constantine S. Georas.

The installation and meeting drew over 125 associ tion members, spouses and friends for dinner an dancing. Dr. Richard L. Testa, retiring President, spok briefly in appreciation to Jim Clarkin, Howard Lawtor and members of his Executive Committee for their hel during the year. He said he felt the association pe formed well in conjunction with the Rhode Island Med cal Society, that the two organizations worked we together on the major issues.

Dr. Moore, newly installed President, thanked th members for electing him to the office. He expresse his concerns and aims in relation to several areas o activity within the association. In particular, he said h believes strongly in the importance of physician patient communications in any medical practice, an he feels that the association has a role to play in this.

The association, in his view, should continuall stress to its members the importance of simple cour tesy and friendship in creating good physician-patien relationships. For example, he would urge colleagues if you need to interrupt a session with a patient, don' say you will be back in just a minute, and then return in 15 minutes. Be a *friend* and be *truthful* — about al aspects of the patient's illness and treatment. Urge nurses and assistants to do the same. Common sens kindnesses are indispensable in the practice o medicine.

Dr. Daniel Moore's Presidential Installation Message:

In the past year, a number of people have asked if we really need the Providence Medical Association. As you know, this organization (as well as the other 6 county and district associations) are components of the Rhode Island Medical Society. Providence has the largest membership of any of these components and therefore the largest number of delegates to the House of Delegates of the Rhode Island Medical Society, 39 to be exact, out of a total of 67. Obviously, this gives us a chance to be heard and influences greatly the policies of the parent organization.

In addition, the association gives us a sense of cohesiveness which we need more than ever in these times of constant and unrelenting infringement by federal and state governments and agencies upon the practice of medicine, particularly because of cost containment. We know that cost containment is important . . . we've had to recognize the reality of this in our personal lives and in our practices for years.

We need this forum to get to know one another, to develop a spirit of camaraderie and to have a link with the past. In so doing, we can refresh our pledges to serve our patients with the highest quality of care and ethics possible.

In serving on the Mediation Committee of the Rhode Island Medical Society in the past year, one of the predominant factors I have been impressed with is the many complaints arising from a lack of communication with patients.

The art of medicine involves not only accurate diagnosis and effective treatment but thorough communication with patients on a level which they can understand. It seems to me that many of the frustrations which patients complain about could be eased by talking with them on a person to person level.

Let us again renew our ideals and pledges to the public in spite of constant pressures and infringements.

Thank you for the honor of electing me to this post. I find that Dick Testa's shoes are already too large for me to fill, but I will do my best.

Care for Developmentally Disabled Infants and Children

Karen Challberg

Two papers were presented to the pediatric staff of St. Joseph Hospital recently on some new concepts which are opening perspectives for diagnosis and care of infants and children with developmental disabilities.

Society needs new definitions and approaches to the care of the developmentally disabled. The scope of its responsibilities to these persons is continually enlarging. Public Law 95-602 (The Rehabilitation, Comprehensive Services and Developmental Disabilities Amendments of 1978) specifically describes developmental disability as a mental *or* physical impairment *or* combination of mental and physical impairment which results in *functional* limitations in specified areas of major life activity. The definition, emphasizing diagnosis in terms of functional limitations, increases the size of the population with rights under the law and also increases responsibilities of state and other agencies in providing treatment and services.

Physicians, therapists, social workers, vocational counselors, special education teachers, and psychologists all make up the rehabilitation team. Physicians' perspective is especially vital. "Developmental pediatrics" is a growing field, and the pediatrician is being required to distinguish, for example, the child who has a communication disorder from the child with retardation, the hyperactive child from the child with emotional difficulties.

The evidence of one of the papers, presented by Dr. Eric Denhoff, notes a reduction in the incidence of cerebral palsy in children, especially of cases attributable to adverse perinatal events, but an increase of neurosensory complications in cerebral palsy infants, and also an increase of neurodevelopmental problems in infants and children due to congenital anomalies. Dr. Denhoff emphasizes the importance of distinguishing signs and behaviors of neurologically impaired compared with environmentally deprived infants at an early stage. Although differential diagnosis between mildly organically impaired and environmentally deprived infants may be difficult, there are clues which can help.

Organically stressed infants are more apt to become hyperexcitable to stress, whereas the environmentally deprived baby is more apt to become apathetic. The organically impaired infant does not achieve normal postures and positions because of inhibiting abnormal reflexes which "lock" the infant into ineffectual postures; while the emotionally deprived baby is more apt to exhibit limp or floppy postures. The organically impaired baby usually can't eat satisfactorily, while the deprived infant generally refuses to eat rather than trying and failing because of neurological limitations.

There is a good deal of controversy about early management programs for mildly impaired babies. However, Dr. Denhoff is optimistic. He urges a positive supportive approach for these babies, regardless of cause of the problem. Even if problems fail to resolve, this will probably at least improve the situation and lessen the need for more intensive care. He also discussed new animal research that offered hope that in young impaired infants, neuronal damage is not fixed. A recent study reported that when the eyelid of one eye in kittens was sutured tight, the ensuing visual deprivation caused regression of neuronal development in the area of the cortex represented by the impaired visual input. However, the cortical area receiving normal visual input widened anatomically to suggest neuronal stimulation and growth in the unaffected cortex to compensate for the lack of bilateral visual input. Such a finding suggests that in many cases of mild to moderate developmental impairment, the delays are not necessarily a reflection of permanent brain damage, but that with appropriate stimulation the affected neurons are capable of vitalization.

A new diagnostic tool is the PSR (Psychological Stimulus Response) test, which was the subject of a presentation by Eileen M. Mullen, EdD, Director of Diagnostics and Evaluation Services, Meeting Street School, East Providence, Rhode Island. Dr. Mullen developed the PSR, which was first reported in the press in April 1978, and is now being used in more than 200 hospitals, agencies and school systems throughout the country.

Eileen M. Mullen, EdD, with patient, Meeting Street School.

The test is nondiscriminatory for the evaluation of disabled children by minimizing motor requirements in the assessment of levels of intellectual development. It provides several alternative ways of responding and demonstrating knowledge, thus optimizing the child's test participation and response capability.

The PSR has two scales — a language scale and a visual-motor scale, which has a tactile awareness section. In the language scale the child responds by vocalizations, word approximations and single words, by shaking or nodding head for "yes" and "no", by using eyes to look at the correct item, and by touching and gross pointing. In the visual scale the child responds by looking, scanning, touching and gross pointing. In the tactile section the child responds by looking, touching or verbalizing.

All but a few of the items in the PSR language and visual-motor scales can be found in a number of well known normative tests such as the Bayley Mental Scale and the Binet. A list of normative sources for each of these test items is included in the test's manual, along with a general reference for tactile items. For *each* test item the child may use any one of the *several* modes of responding.

The PSR test allows the examiner to make hypotheses about relative strengths and weaknesses and to delineate the child's individual learning style. Its great value, says Dr. Mullen, is that it "tests to strengths and serves as a baseline for teaching to strengths."

Physician-Owned Company

Charles L. Hill, MD

The discussion as to the necessity for a physician-owned liability insurance company has proceeded well under the direction of Dr. Louis Vito and Dr. Kenneth Liffman. The House of Delegates, February 27th, voted to introduce legislation to obtain a charter from the General Assembly which would allow further development of such a company.

The energies of our physician-insurance liaison members are now directed toward continued investigation as to the viability of a physician-owned company, as well as possible modifications of the Joint Underwriting Association (JUA).

The advantages of the private company are the sensitivities the physician board of directors would have to peer review, individual ratings depending on performance, and the flexibility of a "family-run organization." tion."

Changes in the JUA would allow the use of modified claims-made and occurrence policies, more physician involvement, and the security of an insoluble state mandated liability company.

Comments can be directed to Dr. Vito or Dr. Liffman.

Expo Science '80:

Six Rhode Island students were named Saturd. March 15 to receive honor awards from the Rho Island Medical Society for their displays at Ex Science '80. Announcement of the science fair awar was made by John C. Lathrop, MD, Chairman of t Medical Society's Committee which included D Daniel Alves, Thomas G. Breslin, Roger Fontaine, K F. Stephens, Barbara A. Fritz and Naeem M. Siddique.

Each of the Medical Society award winners w receive a US Savings Bond and also a framed cert cate.

Cited for honor awards in the Senior Divisi Exhibits displayed at Rhode Island Junior Colleg March 15, 1980 were: Paul Toste of Bristol High Scho for his project, "The Effect of Dietary Iron on Colon Hyperplasia and Synchronic Progression", Victo Mason of Tiverton High School for her exhibit, "TI Effect of Natural and Chemical Inhibitors of Tv Diverse Spore Forming Micro-organisms, Dicty steleum Dicoidium and Bacillus Subtilis", and Josep Mazza of St. Raphael Academy for his proje "Development of a Hybrid Artificial Pancreas".

Junior High School students accorded honor awar for their science exhibits were: Judith Bourassa of S Mary's Academy for her exhibit, "A Case Against Jur Food", Tracey Rollins of St. Paul School for her proje "Cloning: Science Fiction or Reality" and Jamie Sous of Our Lady of Fatima School for her project, "A Sire May Be Sounding in Your Body".

CHAMPUS Form-alities

- If you feel a CHAMPUS allowance is incorrect, a written request for an administrative review must be submitted within 180 days from the date the claim was paid. The review is final. (CHAMPUS allowances have been updated effective for claims processed on or after February 7, 1980.)

- DD Form 2160 or Standard Form 513 must be su mitted with each claim, *if* the referring physician is the Uniformed Services.

Medical Meetings

APRIL 1980

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MAY 1980

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APRIL

*	Rhode Island Chapter, American Academy of Family Physicians; board meeting
9	Washington County Medical Society; business meeting
15	Allergy Foundation; meeting to form a Rhode Island Chapter; 95 Pitman Street, Providence; 7:30 pm
16	New England Pediatric Society; regular meeting; Boston, Massachusetts
16	1st Annual Community Pediatric Hospital Day; Kent County Memorial Hospital
17	RIMS Past Presidents Advisory Council; dinner meeting; RIMS Building; 6:00 pm
21	Rhode Island District Branch, American Psychiatric Association; Annual Meeting; Aboretum Restaurant, East Providence

MAY

3	Rhode Island Chapter, American Academy of Family Physicians; Annual Meeting; Rhode Island Inn, Warwick
4	Providence Medical Association Auxiliary; Trinity Square Night
9	St. Joseph Hospital Medical Staff; meeting; Alpine Country Club, Cranston
14	RIMS Annual Meeting; Cranston Hilton; (In conjunction will be meetings of RI District Branch, American Psychiatric Association; RI Society of Pathologists; RI Chapter, American College of Physicians; RI Chapter, American Academy of Pediatrics; RI Chapter, American College of Emergency Physicians; RI Society of Allergy; joint meeting of the Providence Surgical Society and American College of Surgeons; RI Society of Nuclear Medicine)
15	Pawtucket Medical Association; Annual Meeting
17-21	Rhode Island Chapters, American College of Surgeons and American College of Physicians; joint meeting; Elbow Beach Hotel, Bermuda
22	Newport County Medical Society; dinner meeting and election of officers; Canfield House; 6:30 pm
24	Rhode Island Dermatological Society; regular meeting; The Memorial Hospital; 8:30 pm
*	Rhode Island Society of Internal Medicine; Annual Meeting; (May 28 tentative date)

*Date to be decided

DEAN'S MESSAGE

Some Problems Facing Medical Education in the Decade Ahead

Of the many prophesies offered for the decade ahead, the likeliest to achieve fulfillment is the one predicting the inevitability of change — and in ways which are virtually unpredictable. In the year 1970 few people in medical education could have foretold the vast transformations in societal and professional priorities, attitudes, problems and resources which characterize the year 1980. To believe in the future requires us to define it and hopefully prepare for it. The National Fund for Medical Education has recently attempted to identify some of the unsettled questions which we think will confront the US medical schools in the decade ahead; and however wrong our projections will ultimately be proven to be, we are nevertheless obliged to record them.

1. *Physician manpower:* The appropriate number of physicians to be graduated from US medical schools is a complicated issue which does not yield to simple solutions. While we are now told that there may be physician surpluses before us, other perceptions and analyses suggest otherwise. Should the US medical schools confront this problem (ie, practice birth-control on the number of its graduates) in the decade ahead? What will be the impact of an increasingly aging population and the likelihood of some form of national health insurance on future manpower requirements?

2. *The quality of future physicians:* There has been a steady drop in the number of US medical school applicants during each of the past five years. If this trend persists, might this signify a shortage of applicants in the decade ahead? Will the quality of the future medical student cadre be correspondingly diminished? Will increasing government regulation lessen further the attraction of medicine as a career?

3. *The supply of future medical faculty:* Private practice, as perceived by recent medical school graduates, is becoming more prestigious while a career in academic medicine is viewed as subject to increasing fiscal and regulatory constraints. Accordingly, the number of medical students preparing for academic careers is falling precipitously and the number of unfilled medical faculty positions is rising. Where will our future medical school teachers come from? Should some students be specially selected and trained for academic careers? What can be done about the parallel declining interest among medical students in biomedical research centers?

4. *Continuing medical education:* A number of state legislatures, including Rhode Island's, have passed laws requiring evidence of continuing medical education for medical relicensure purposes. Is there evidence that CME increases the quality of medical care rendered? If some kinds of CME are effective, are they also cost-effective?

5. *Life-long learning:* In contrast to continuing medical education (which is a formalized system often with extrinsic rewards and certifications), life-long learning is a personally motivated phenomenon and depends on private learning for the sake of learning. How can we convey to our students those positive attitudes which encourage the spirit of life-long learning? Do physicians have other learning needs beyond those of medicine (such as in the arts, humanities and physical sciences) which should be similarly encouraged?

6. *The role of physicians in educating patients:* Schools of medicine exert most of their efforts in training the future physician in the diagnosis and treatment of disease rather than in preparing him/her as an educator. Today's patients are better educated, are more capable of understanding the nature of their illnesses and seek more control over their personal health as well as the factors which may modify their health. How may medical students be taught to listen and communicate better with their patients? Can they be taught to motivate patients to assume greater personal responsibility for their health? Do medical students understand the origins and

pervasiveness of patient non-compliance? Can our future doctors be educated to develop more cooperative and less authoritarian attitudes toward their patients?

7. *Distressed physicians:* The rates of drug abuse, emotional disorders and suicides are higher among doctors than in the remainder of the population, and represent a tragic source of attrition within the profession. (The numeric equivalent of one medical school graduating class per year is lost because of these disorders). Can individuals vulnerable to these tragedies be somehow identified before they are accepted to medical school or at least while they are still undergoing their professional education? Can special and more effective counselling be provided to lessen the frequency of these disorders?

8. *Mental health:* In 1977 a Presidential Commission had reported that one-fourth of the American population undergoes some form of severe emotional stress and at any one time an estimated 20-30 million Americans are in need of some kind of mental health care. Does our present system of medical education truly prepare future doctors to treat or prevent emotional problems of patients?

9. *Measuring and maintaining quality of care:* Where in medical education can quality control methods be most effectively taught?

10. *Environmental and occupational health:* Over 80 million Americans spend half of their waking hours in the work-place where machinery, noise and environmental pollution represent compelling hazards and call for vigorous preventive and therapeutic measures. These environmental factors constitute a major source of illness in an industrialized society. Indeed, some scientists make the claim that cancer as a major threat to health is but an historically recent event coincident with industrialization. What are the best ways to sensitize medical students to the role of environmental hazards? How can occupational medicine be made a more attractive field? Should medical schools become involved in training non-physician personnel for surveillance in occupational health?

11. *Health care of adolescents:* The health care problems of adolescents are considerable and include proneness to physical trauma, promiscuous usage of drugs and destructive behavior directed toward others as well as themselves. Can we teach adolescent care to medical students in unconventional settings such as high schools and social agencies? Can we interest our future physicians in exerting their professional efforts toward the neglected grey-zone between pediatrics and adult medicine? What is the role of the future physician, for example, in managing the complex problems which surround adolescent pregnancy?

12. *Technology assessment:* Medical technologies are costly and require careful evaluation before their widespread use. Should certain physicians be trained for future careers in technology evaluation? Might the principles of technology assessment be introduced into medical school curricula?

13. *The cost of health care:* This nation does not presently possess the resources to provide all of the health care needs for each of its citizens. Some form of rationing is therefore required in the distribution of certain health services. How can an awareness of cost be extended to each medical school teaching exercise? Can our medical students be sensitized to the ethical meanings of cost-control and triage?

The thoughts of the readers with regard to these problems, or yet other problems which they feel merit attention, would be welcomed.

Stanley M. Aronson, MD
Dean of Medicine
Brown University

EDITORIAL

Hip Fractures

A recent paper from the Mayo Clinic emphasizes the magnitude of the problem of fractured hip in the elderly. The report is one of a series of "Defined Population" epidemiological studies carried out on the population of Rochester, Minnesota, the home of the Mayo Clinic. Virtually all residents of the community are heard either at the Mayo Clinic or by physicians of the Olmstead Medical and Surgical Group in the clinics or in a system of affiliated hospitals.

The study covering a 3-year period (1969-1971) embraced all limb fractures occurring in the population of the Rochester area. This amounted to 2,519 individual fractures in 2,333 patients.

As the authors emphasize, the single most striking finding of the study was the contribution of fractures of femoral head and neck to the utilization of hospital bed days and physiotherapy. Although they comprised only 7.3 per cent of all limb fractures occurring in the defined population during the period covered, fractures of the femoral head and neck constituted 27 per cent of all hospital admissions for fractures and amounted to 52 per cent of all bed days, more than all other anatomic sites combined. Furthermore, one out of every five patients with hip fractures received physical therapy thus utilizing 56 per cent of all physiotherapy sessions devoted to limb fractures.

This study does not address directly the great charge upon health care resources, the economic burden, and the social dislocation which these fractures characteristically generate. It does, however, mention the increasing rate of hospital admissions for these fractures in recent years and points to their "overwhelming impact" on the utilization of health care resources. Blue Shield of Massachusetts reports that open reduction of hip fractures is the ninth most common operation performed in that state.

While operative treatment has made great strides over the years, better prevention and even more effective management than is presently available would appear to be important objectives.

References

1 Garraway WM, Stauffer RN, Kurland LT, O'Fallon WM: limb fractures in a defined population. I. Frequency and distribution. *Mayo Clin Proc* 54:701-707, Nov 79

2 Garraway WM, Stauffer RN, Kurland LT, O'Fallon WM: Limb fractures in a defined population. II. Orthopedic treatment and utilization of health care. *Mayo Clin Proc* 54:708-713, Nov 79

Medical Melange for 1910 — How things were back then in St. Louis and America — The MSMA (Missouri State Medical Association) will meet in Hannibal this May, with the Mark Twain Hotel headquarters (rate, American plan $2 to $3 a day) . . . Dr. Harvey Cushing, head surgeon of the Johns Hopkins Hospital, has accepted the office of surgeon-in-chief of the proposed Peter Bent Brigham Hospital, the new teaching facility of Harvard University Medical School. Dr. Henry Christian, Dean of the Medical school, will be physician-in-chief . . . Most gratifying reports continue to come to the professors relative to phenomenal efficacy of the long-desired specific for syphilis. This is '606' arseno-benzol. Time alone can demonstrate permanence of its curative effect.

. . . *Extracted from* St. Louis Metropolitan Medicine, *November 28, 1979*

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LETTERS

Lady Physicians

To the Editor:

After Elizabeth Blackwell gained the distinction of being the first woman to be awarded a medical degree in this country in 1849, few women gained access to the profession for many years. However, with the prospects of more female doctors in the mid-1880s panic evidently struck the male population.

This concern is well delineated in an editorial which appeared in the Chicago Times around 1883, a copy of which is enclosed.

I found this gem while perusing a scrap book compiled by a Cumberland resident who was graduated at the age of fifteen from the Grove Street Grammar School in Pawtucket in June 1883.

Despite the prediction of doom another potential iatrogenic adverse effect has been discounted by time.

"A St. Louis doctor factory recently turned out a dozen female doctors. As long, says *Peck's Sun,* as the female doctors were confined to one or two in the whole country, and those were only experimental, we held our peace and did not complain; but now that the colleges are engaged in producing female doctors as a business we must protest, and in so doing will give a few reasons why female doctors will not prove a paying branch of industry.

"In the first place, if they doctor anybody it must be women, and three-fourths of the women would rather have a male doctor. Suppose those colleges turn out female doctors until there are as many of them as there are male doctors, what have they got to practice on? A man, if there was nothing the matter with him, might call in a female doctor, but if he was sick as a horse (if a man is sick he is sick as a horse), the last thing he would have around would be a female doctor. And why? Because, when a man has a female fumbling around him he wants to feel well. He don't want to be bilious or feverish, with his mouth tasting like cheese and his eyes bloodshot, when the female is looking him over and taking account of stock.

"Of course these female doctors are all young and good-looking, and if one of them came into a sick-room, where a man was in bed, and he had chills, and was as cold as a wedge, and she should sit up close to the side of his bed and take hold of his hand, his pulse would run up to 150, and she would prescribe for a fever when he had chilblains. Oh, you can't fool us on female doctors. A man who has been sick, and had male doctors, knows just how much he would like to have a female doctor come tripping in and throw her fur-lined cloak over a chair, take off her hat and gloves and throw them on a lounge, and come up to the bed with a pair of marine blue eyes, with a twinkle in the corner, and look him in the wild, changeable eyes, and ask him to run out his tongue. Suppose he knew his tongue was coated so it looked like a yellow Turkish towel, do you suppose he would want to run out over five or six inches of the lower part of it and let that female doctor put her finger on it to see how furred it was? Not much. He would put that tongue up into his cheek, and wouldn't let her see it for twenty-five cents admission. We have all seen doctors put their hands under the bed-clothes and feel of a man's feet to see if they were cold. If a female doctor should do that it would give a man cramps in the legs. A male doctor can put his hand on a man's stomach, and liver, and lungs, and ask him if he feels any pain there; but if a female doctor should do the same thing, it would make a man sick, and he would want to get up and kick himself for employing a female doctor. Oh, there is no use talking, it would kill a man.

"Now suppose a man has heart-disease, and a female doctor should want to listen to the beating of his heart. She would lay her left ear on his left breast, so her eyes and rosebud mouth would be looking right in his face, and her wavy hair would be scattered all around there, getting tangled in the buttons of his night shirt. Don't you suppose his heart would get in about twenty extra beats to the minute? You bet! And she would smile — we will bet ten dollars she would smile — and show her pearly teeth, and the ripe lips would be working as though she were counting the beats, and he would think she was trying to whisper to him, and _____. Well what would he be doing all this time? If he was not dead yet, which would be a wonder, his left hand would brush the hair away from her temple and kind of stay there to keep the hair away, and his right hand would get sort of nervous and move around to the back of her head, and when she had counted the beats a few minutes and was raising her head he would draw the head up to him and kiss her once for luck, if he was as bilious as a Jersey swamp angel, and have her charge it in the bill. And then a reaction would set in, and he would be as weak as a cat, and she would have to fan him and rub his head till he got over being nervous, and then make out his prescription after he got asleep. No; all of a man's symptoms change when a female doctor is practicing on him, and she would kill him dead."

Sidney I. Brody, MD
Cumberland, Rhode Island

■

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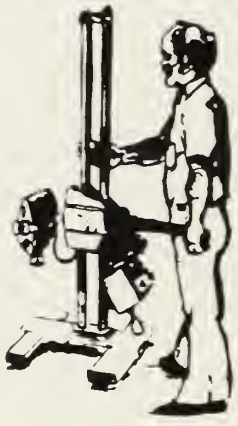

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Please see last page for brief summary, including warnings, precautions, and adverse reactions.

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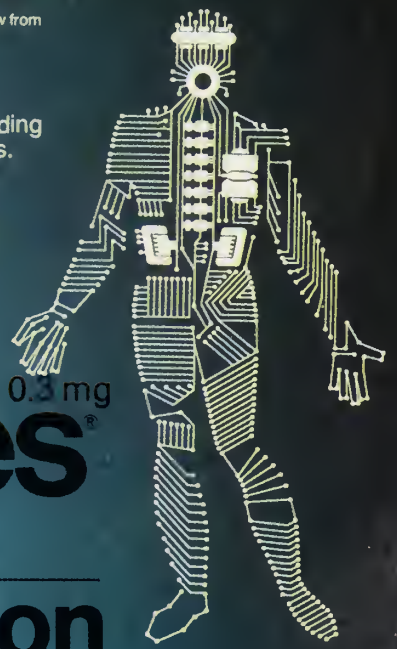

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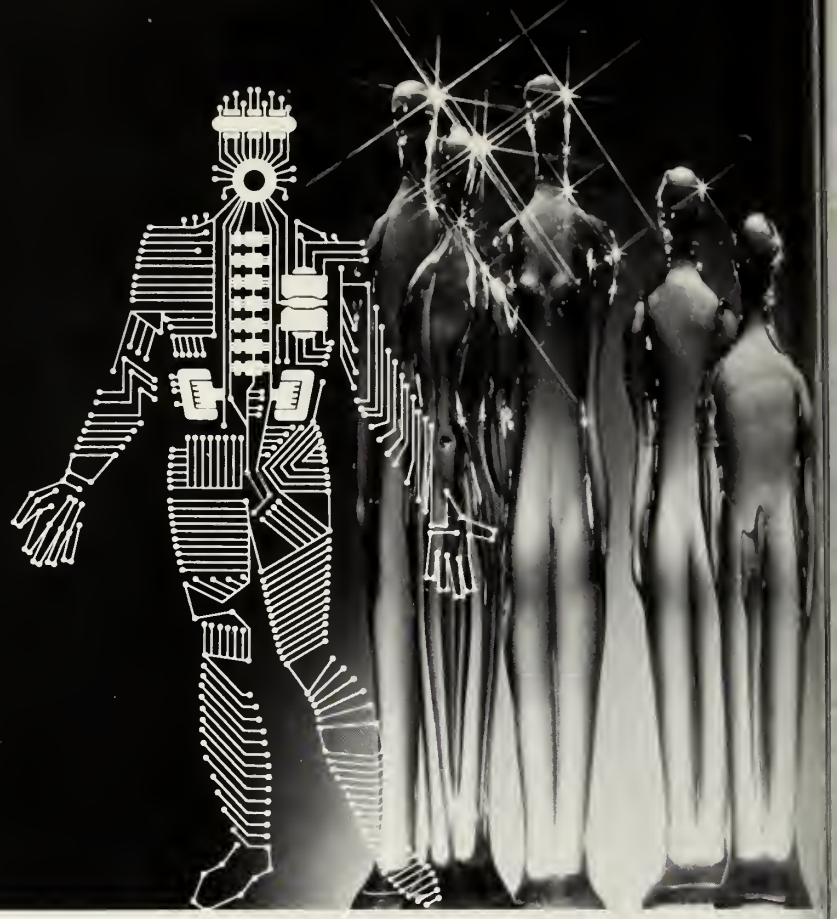

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Warnings: Tolerance may develop in some patients necessitating a reevaluation of therapy.
Usage in Pregnancy: In view of embryotoxic findings in animals, and since information on possible adverse effects in pregnant women is limited to uncontrolled clinical data, the drug is not recommended in women who are or may become pregnant unless the potential benefits outweigh the potential risk to mother and fetus.
Usage in Children: No clinical experience is available with the use of Catapres (clonidine hydrochloride) in children.

Precautions: When discontinuing Catapres (clonidine hydrochloride), reduce the dose gradually over 2 to 4 days to avoid a possible rapid rise in blood pressure and associated subjective symptoms such as nervousness, agitation, and headache. Patients should be instructed not to discontinue therapy without consulting their physician. Rare instances of hypertensive encephalopathy and death have been recorded after cessation of clonidine hydrochloride therapy. A causal relationship has not been established in these cases. It has been demonstrated that an excessive rise in blood pressure, should it occur, can be reversed by resumption of clonidine hydrochloride therapy or by intravenous phentolamine. Patients who engage in potentially hazardous activities, such as operating machinery or driving, should be advised of the sedative effect. This drug may enhance the CNS-depressive effects of alcohol, barbiturates and other sedatives. Like any other agent lowering blood pressure, clonidine hydrochloride should be used with caution in patients with severe coronary insufficiency, recent myocardial infarction, cerebrovascular disease or chronic renal failure.

As an integral part of their overall long-term care, patients treated with Catapres (clonidine hydrochloride) should receive periodic eye examinations. While, except for some dryness of the eyes, no drug-related abnormal ophthalmologic findings have been recorded with Catapres (clonidine hydrochloride), in several studies the drug produced a dose-dependent increase in the incidence and severity of spontaneously occurring retinal degeneration in albino rats treated for 6 mont longer.

Adverse Reactions: The most common reactions are dry mouth, drowsines sedation. Constipation, dizziness, headache, and fatigue have been repo Generally these effects tend to diminish with continued therapy. The follo reactions have been associated with the drug, some of them rarely. (In s instances an exact causal relationship has not been established.) These inc Anorexia, malaise, nausea, vomiting, parotid pain, mild transient abnormaliti liver function tests; one report of possible drug-induced hepatitis without ic and hyperbilirubinemia in a patient receiving clonidine hydrochloride, c thalidone and papaverine hydrochloride. Weight gain, transient elevation of l glucose, or serum creatine phosphokinase: congestive heart failure, Rayn phenomenon; vivid dreams or nightmares, insomnia, other behavioral char nervousness, restlessness, anxiety and mental depression. Also rash gioneurotic edema, hives, urticaria, thinning of the hair, pruritus not assoc with a rash, impotence, urinary retention, increased sensitivity to alcohol, dryr itching or burning of the eyes, dryness of the nasal mucosa, pallor, gynecom weakly positive Coombs' test, asymptomatic electrocardiographic abnorma manifested as Wenckebach period or ventricular trigeminy.

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PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs

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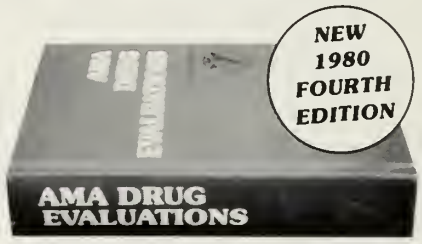

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Life-Stress and Depression Symposium

Introduction

Robert J. Westlake, MD

The stress generated by ordinary and unusual life situations is increasingly recognized as a factor predisposing to major illness. Clusters of stressful experiences referred to as "life crises" are also gaining increasing attention as episodes effecting the health of patients. Stress is no longer primarily linked to specific "psychosomatic" illnesses, but rather seen as an underlying factor which accentuates health problems and robs many individuals of their sense of well-being, and ability to perform at their full potential.

Practicing physicians are well acquainted with pressures in their own daily lives and in the lives of their patients. Such pressures are not necessarily a negative factor and for most persons the proper amount of stress provides motivation and adds meaning and excitement to life. For some, however, mastery and positive adaptation are impossible and clinical symptoms may develop.

A frequent maladaptive response to stress is the familiar syndrome of loss of interest and diminished function which characterizes the onset of a depressive illness. Depression appears in many forms and often masquerades as somatic illness or for other reasons goes unidentified. The high prevalence of unrecognized depression causes a great deal of unnecessary suffering and contributes to suicide being the nation's tenth leading cause of death.

The relationship between stress and depression is complex with multiple demographic, social, and personality factors shaping individual coping patterns. The physician is often called upon to help the patient moderate his response to stress and to help in the development of successful coping mechanisms. In order to do so the doctor must understand the sources of stress, recognize the early signs of clinical depression, and know how to intervene effectively.

The papers presented in this issue of the *Journal* represent an abbreviated form of some of the presentations made at a 1978 Rhode Island "Symposium on Life-Stress and Depression" attended by approximately 300 physicians. The program was presented under the auspices of the Brown University Section of Psychiatry and Human Behavior, Butler Hospital, and the Brown University Section of Family Practice in cooperation with the Rhode Island Medical Society, the Rhode Island Chapter of the American Academy of Family Physicians, and the Rhode Island District

Robert J. Westlake, MD, *Associate Professor of Psychiatry and Human Behavior, Brown University Program in Medicine, Providence, Rhode Island; Assistant Medical Director, Butler Hospital, Providence, Rhode Island.*

Branch of the American Psychiatric Association. The program was supported by an educational grant-in-aid from, and with the administrative assistance of, the Geigy Symposia Series, Summit, New Jersey.

Papers by Doctors Rahe, Hochheiser, Westman, and Clayton examine some of the life events, work, family, and developmental stress which are common in our lives and the lives of our patients. The papers by Weissman and Meyers and by Modlin focus on depression itself, and upon suicide.

As a group the papers emphasize the significance of psychological stress factors and coping mechanisms in the genesis of depressive illness. The physician is urged to become more sensitive to predisposing stress factors, to depression, and methods of early intervention.

The large attendance at the original symposium demonstrated considerable interest in integrating psychiatric concepts into general medical practice, and for that reason a selection of papers from the symposium is now presented in the *Journal.*

Butler Hospital
345 Blackstone Boulevard
Providence, Rhode Island 02906

I. Recent Life Change Stress and Psychological Depression

Richard H. Rahe, MD

The historical roots of stress concepts reside in the realm of philosophy as well as in medicine. For example, Descartes can be credited with the articulation of a dissociation between mind and body which still hampers modern day conceptualizations of stress and its effects. In the pursuit of his "philosophical reductionism" Descartes argued for the basic independence of the mind, especially in terms of thoughts and emotion, from the functions of the body. Counterbalancing Descartes' view was that of Spinoza. Spinoza emphasized the desirability of harmonious integration of a person's thoughts and emotions with his bodily functions and health. Spinoza, a noted religious philosopher, was influenced in his formulations by the religions of China and Japan.

In the 19th Century, Pavlov repeatedly stated that the functions of the brain could be investigated in the same physiological manner as those employed in investigations of bodily functions. Claude Bernard was impressed by the balance of physiological systems. His observations on the consistency of the "internal milieu" led him to conceptualize key elements pertaining to the body's maintenance of vital functions despite various environmental influences tending to alter these functions.

In the 20th Century, experiments which displayed the close integration of mind and body were conducted by physicians such as Walter B. Cannon and Hans Selye. By mid 20th Century, Harold G. Wolff's laboratory at Cornell University exerted profound effect on our current thinking regarding measurement of life stress. Wolff, in turn, had been strongly influenced by the Swiss-American psychiatrist Adolf Meyer. During Meyer's tenure as Head of Psychiatry at the Johns Hopkins Medical

This Report No. 79-11 is supported by the Department of the Navy, Bureau of Medicine and Surgery, under work unit ZF 51.524.022-5020. The views presented are those of the author. No endorsement by the Department of the Navy has been given or should be inferred.

Richard H. Rahe, MD, *Captain, Medical Corps, US Navy; Commanding Officer.*

School, he taught the use of his life chart in collating patients' biographical and biological health data. One of Dr. Wolff's colleagues, Thomas H. Holmes, extended work on the life chart approach, and in collaboration with sociologist David Hawkins devised the first recent life changes questionnaire. As a medical student I worked with Dr Holmes in revising Hawkins's questionnaire to specify more clearly the life change events being measured in order to achieve a sampling of events from five major aspects of life adjustment: health, work, family, personal, social, and financial[1]. I also initiated studies designed to determine estimations of magnitude for the various life change events on the questionnaire[2].

Recent Life Changes Measurement

Although it should be mentioned that there is no unanimity of opinion among researchers today as to a definitive list of recent life change events, one of the first lists published was the one by Holmes and Rahe[2]. The original list contained 43 life change events. My revised list, which I've used over the past decade, contains 71 events. It was always my intent to sample events from key aspects of life adjustment, rather than to cover all possibilities.

The concept of *change* was used to quantitate life events because of pioneering work by physiologists such as Bernard and Cannon. Assuming that a person's psychosocial adjustment is also maintained in some sort of balance, as in physiological homeostatic systems, psychosocial demands should cause temporary shifts in this balance with a return to normal state after a period of time. Thus, the amount of change from previous psychosocial balance produced by recent life change events was used to determine our units of stress.

The results of our studies indicated that groups of individuals showed remarkable agreement as to average degrees of life change and readjustment engendered by each of the events on the list. Later cross-cultural studies confirmed these earlier findings[3,4].

Recent Life Change Events and Depression

I shall now attempt to put in perspective how an individual's recent life change events may be related to the onset of psychological depression. To do so I shall use examples derived from the science of epidemiology. Life change events can be considered in many respects as an environmental "risk factor" for the development of depressive illness.

I think everyone in this audience is aware of how one's level of serum cholesterol is considered an environmental risk factor for the development of coronary heart disease (CHD). When you look at these serum cholesterol data from an epidemiological point of view you find that, although it's true that people who develop CHD generally have significantly higher serum cholesterol levels than people who remain free of this disease, the majority of persons with high serum cholesterol *never* develop CHD. This is a seeming paradox, until you realize that the universe of persons with elevated serum cholesterol levels is very large and the portion of that universe who go on to develop CHD is quite small. Accordingly, there are far more false positives than true positives for this risk factor.

The same observations hold true for recent life change events and psychological depression. Depressed patients presenting at an outpatient clinic tend to report more recent life change events than do health controls[5]. Inpatients with depressive disorders report even higher levels of recent life change. Suicidal patients report highest levels, a four-fold increase over control values[6]. Once again, the universe of persons with elevated recent life changes is very large. The majority of the persons in this universe remain in good spirits, and only a small proportion go on to develop depression. As with serum cholesterol and coronary heart disease, there are far more false positives than true positives with this risk factor.

Recent Life Change and an Illness Onset Model

Perhaps the best way to present the influence of recent life change events upon the onset of psychological depression is by the use of an optical model[7]. If one conceptualizes subjects' recent life change events as a series of light rays passing through a number of lenses and filters, the distortion produced upon these light rays by the various lenses and filters represents the modifications by subjects' personal characteristics of the impact of these events. The first filter through which recent life change events pass is a polarizing filter. This polarizing filter symbolizes subjects' perceptions. That is to say, some individuals per-

ceive recent life change events as more difficult, or less difficult, to adapt to than does the average individual. Thus, an individual may have a very different subjective interpretation of a recent life change event than does the average person, due to his own perceptive biases. Next in this model is a negative lens. This negative lens symbolizes psychological defenses. It has been demonstrated that some psychological defense mechanisms, such as repression and denial, essentially divert the normally arousing effects of significant recent life change events[8]. However, most recent life change events of significant magnitude are both perceived by the individual and not totally defended against, causing some degree of physiological arousal.

The "energy" emanating from physiological arousal in the model then passes through a color filter. This color filter represents a person's coping capabilities. Coping capabilities may selectively "absorb" physiological arousal (symptoms) secondary to recent life change experience. The last lens in the model is a positive lens which represents illness behavior. A number of people perceive their recent life change events as significant, do not entirely defend against them, have some secondary physiological arousal, and fail completely to cope with resultant symptoms, but nevertheless fail to report these symptoms to a medical authority. Thus, these symptomatic persons never receive a diagnosis or medical treatment. It is only when individuals' illnesses are diagnosed and recorded that studies of recent life change events and illness cases can be carried out.

Once again utilizing the epidemiologic model, recent life change events in the lives of persons developing psychological depression (entered on medical records) represent only a small proportion of the universe of persons exposed to recent life change stress. Most persons so exposed either don't perceive these life changes as threatening, or successfully defend against them, or cope extremely well with resultant symptoms, or go on to become symptomatic, or any combination of these, but never report their symptoms to medical personnel.

Summary

In this brief discussion I have presented some of the historical roots of stress concepts as well as information regarding the derivation of a questionnaire which measures recent life change experience as one aspect of recent life stress. Not only can recent life events be inventoried, but some estimation of the magnitudes of these events can be ascertained. Several studies have indicated that recent life change events occur more frequently in subjects' lives who report psychological depression than in normal controls. Although recent life change can serve as an environmental risk factor to identify those at elevated risk of developing psychological depression, far more false positives than true positives will be classified. Therefore, to evaluate persons' recent life stress for its possible influence leading to psychological depression, it is more helpful to trace the effects of recent life changes through the patient's perception, his psychological defenses, his coping skills, and his illness behaviors. Only after this has been done can the clinician obtain a clear understanding of an individual's recent life change stress and his illness susceptibility.

References

1 Rahe RH, Meyer M, Smith M, et al: Social stress and illness onset. J Psychosom Res 8:35-44, Jul 64
2 Holmes TH, Rahe RH: The social readjustment rating scale. Psychosom Res 11:213-218, Aug 67.
3 Rahe RH. Multicultural correlations of life changes scaling. America, Japan, Denmark, and Sweden. Psychsom Res 13:191-195, Jun 69
4 Rahe RH, Lundberg U, Bennett L, et al. The social readjustment rating scale: a comparative study of Swedes and Americans. Psychosom Res 15:241-249, Sep 71.
5 Paykel E S, Myers JK, Diendt MN, et al. Life events and depression. Arch Gen Psychiat 21:753-760, Dec 69.
6 Paykel E S, Myers JK, Diendt MN, et al. Life events and depression. Arch Gen Psychiat 21:753-760, Dec 69.
BP (eds): Stress Life Events: Their Nature and Effects. New York, John Wiley & Sons, 1974.
7 Rahe RH, Arthur RJ. Life change and illness studies: past history and future directions. Human Stress 4:3-15, Mar 78.
8 Wolff CT, Friedman SB, Hofer MA, et al. Relationship between psychological defense and mean urinary 17-hydroxycortico-steroid excretion rates: I. A predictive study of parents of fatally ill children. Psychosomatic Medicine 26:576-591, Sep-Oct 64.

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One Sentence Essay — Definition — Serendipity: *When you're looking for a needle in a haystack and find a girl.*

. . . *Anonymous*

II. Stress Effects of Changing Roles and Work Events on Midlife

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The past few years have resulted in a considerable amount of research and writing about adult development. Although it would be impossible to do an in depth analysis of this material within the scope of this paper, hopefully it will introduce important concepts which will stimulate one to further learning. As one views adult development as dynamic rather than stationary, it is clearly necessary to reexamine concepts regarding adult life changes in general and especially related to work roles. There is an increasing awareness that the apparent goal to reach a point of stability, especially regarding one's work, by the end of the fourth decade is a societal norm. This norm may not be based on the needs of individuals and can negate an individual's recognizing and dealing with their sensitivities.

It is important that health providers know: 1) the normals of adult development; 2) that life is a series of transitions and stable periods (rather than a straight progression); 3) that work motivations change through the years (These changes may create problems during midlife.); 4) that work role problems are often unrecognized by health professionals; and 5) that work role problems can cause significant symptoms seemingly unrelated to work situations.

It appears from the work of Levinson and others that our lives are a series of developmental phases alternating between transitional and stable periods. The transitional periods allow the potential for change in one's existing life structure and the possibility of creating a new role. Transition periods, depending upon the strength of environmental influences, eg, family, job, and economics, may also be periods of reexamination of role, leading to no significant change. On the other hand, if existing pressures during transition periods dictate that a significant role change take place, then the outcome of the period will sometimes lead to marked family and work realignments. The stable periods on the other hand seem to provide opportunities to build structure around one's life choices. These periods of building and solidification last seven to ten years and, although relatively stable, still include some of the conflicts and difficulties of everyday life.

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Midlife Transition

The midlife transition period appears to be one of three critical times related to work role and perhaps the most important of the three. This transition period occurs for most people between the years 35 and 45, although prolonged education may delay the transition and jobs requiring physical prowess may create an earlier transition. So too, a significant life event such as divorce or death of a spouse can precipitate a midlife transition period.

Today it *is* valid not to have a ten year plan. It is becoming legitimate to seek new careers at midlife if those options are available. Indeed, some have suggested that a most appropriate life would include three careers, one in the third and fourth decades, one in the fourth and fifth and yet another from age 60. These careers would be based upon an individual's development and could occur in either related or unrelated fields. One can easily see how difficult it is for a high school student to choose a role for the rest of his/her life. It is realistic to consider that we may be able to create a work role that is satisfying at age 30 which also will provide the same positives at age 50? More and more of the population seems to be discontented in their work roles, particularly as they approach the fifth decade. In the past, work was a duty performed to achieve and to obtain necessities.

Today's society now feels that work, in addition to economic rewards, must provide satisfaction and happiness. Unions have become as interested in work conditions (such as shorter work weeks) as they are in dollars.

During the midlife, if the work situation is unsatisfactory, the terms "stuck", "hemmed in", "caged", "bored" are often used. Change comes with difficulty. Risks are hard to take at a time when financial security, or at least equanimity, has been reached. However, the price of security is often costly in terms of personal and family growth and interaction. Possibly the expectations to develop a career and to maintain this career results in undeveloped talent and a frustration and depression that outweigh the stability.

Work Motivation

One way to look at work motivation is through the basic work emotions. Gould describes five basic work emotions — the meaning of work for those that have some choices can be related to these five issues. The importance of these issues will change as one moves through the stable and transition periods. The five emotions are: 1) invulnerability; 2) necessity; 3) the need to be part of an organization or field with its own intrinsic meaning; 4) an individual's psychodynamic makeup; and 5) the need to express and exercise a full range of our talents and capacities.

Getting bigger or wanting to be invulnerable goes back to our childhood development, where we had a fantasy that in order to overcome our physical and personal injuries all we had to do was to become bigger. Having an important work position is translated to mean that a sibling would not get more candy than you received. Corporate presidents don't vomit in their offices. Doctors don't receive injections, they give them. Children want to be Superman, firemen, doctors, heros. So, too, the powerful man commands a woman's attention. A mother's "don't bother me now, I'm busy" would never happen. The childhood fantasy is to become an invincible person who never is slighted or small, like a child. This is carried into the adult work role where one tries to create a situation where neither illness, financial problems, nor home difficulties will exist after achieving success at work. It is at the midlife when the realization comes that invulnerability is not possible and that the major reason that motivated one to achieve at work, although serving an important purpose to this point, is no longer reality. Work success cannot protect one from problems, sickness, or death. This growing bigger or invulnerability, along with necessity (or economic needs), and the need to belong as part of an organization or a field that has intrinsic meaning, are the three major forces that influence careers during the 20s and 30s. The necessity of obtaining the funds to provide basic food and shelter and then some of the common luxuries for oneself and family begins even before a career starts and has been laid out as an expectation for all men from the preteen years. Only as some security in economic status is achieved does the "necessity drive" reduce. It may become a significant factor in avoiding risk taking and making changes that would lead to a happier and fuller life later on.

Need For Belonging

The need for belonging is a strong motivation that allows prestigious organizations and companies to recruit talent that smaller groups cannot attract, even though the individual's long term potential may be greater with the less prestigious company. Our needs for reinforcement of self-esteem and our narcissistic needs are met more easily by a position at Harvard rather than Podunk University, even though freedom, creativity, and economic rewards may be better at the lesser known of the universities. Belonging to a prestigious organization also can work as a factor to keep an individual from making changes, particularly if the change means a move to a lesser known work situation.

During the midlife transition period two basic work emotions, the individual's psychodynamic makeup and the need to express and exercise a full range of talents and capacities become foremost.

The psychodynamic reason for working is a culmination of many environmental social and developmental influences that have created a "self". During the midlife transition period, frequently questions about one's roles occur — questions such as "What am I?" "Who am I?" "Why am I doing this?" "Is this really what satisfies me?" There is a distinct possibility that a disparity between the present work role and one's dreams may exist. Expectations for success may be unmet. If brought to consciousness, these expectations can be

reexamined, made more realistic; and a period of adjustment and reorganization occurs. If kept in the unconscious realm, depression or anger, which are frequently misdirected, are likely to be manifest. Even if success is achieved, the transition period can still result in turmoil, as shown in studies of corporate executives. Those who have "made it" are frequently depressed. The coping, driving life-style which allowed them to achieve success may no longer be needed. There is nowhere to go when the top of the ladder has been reached.

Need to Fulfill One's Role

Closely related to the psychodynamic work motivations is the need to fulfill one's role, allowing talents and capacities to become fully developed. For some lucky people this happens in their chosen role. For many, however, this would require a role shift, creating potential economic instability and perhaps family instability. It is clear that the economic rewards remain a strong motivation. If the rewards are great enough in one's career, they can overcome the desire to develop other talents. It is of some interest that physicians, because of their potential to find work wherever they choose and significant flexibility in roles as well as a relatively higher economic scale, may fail to be aware of role shift problems in the families they care for.

Although much of the data come from professionals, there is evidence that blue collar workers undergo similar transitions. There is the experience of the 200 New York policemen and firemen who have become nurses through special night courses at Hunter College. They also experience shifts in the importance of basic work motivation from reaching invulnerability, necessity, and belonging to personal psychodynamic issues and needs fully to develop their talents.

Laborers may go through the transition at an earlier age and possibly are more at risk for problems that will interfere with life processes. Take for example the 30 year old laborer who has not become a foreman. Suddenly, even though he is making a good living, he finds 18 and 20 year olds being able to outwork him and begins thinking about how long he will be able to maintain this role. If no outlet is available to understand or change his role, then frequently we will see problems of psychosomatic complaints, alcoholism, marital strife, and extra-marital affairs. Developmental arrest may also occur, resulting in a life which lacks motivation, interests, or happiness.

It is important, as health professionals, for us to be aware of the life change issues in almost every patient interaction. The fourteen year old who is having difficulties with Dad, or a woman of 32 with bruises inflicted by her husband at a time he was drunk, may be indications of midlife transition difficulties. It seems important that physicians understand enough about these midlife developmental problems to be able at least to identify the issues and help people obtain appropriate assistance.

Most people have a midlife or transition period where basic work emotions shift from the motivations to work to become (1) invulnerable, (2) to work because of the necessity to achieve financial stability, and (3) to work to belong to an occupation or field, to greater concern with maximizing one's talents and meeting one's psychodynamic reasons for work. During the transition period irrational and inexplicable behavior may occur with the underlying dynamic being the midcareer work role issues. If the transition is denied, anxiety and problems increase. People can become work centered and stay away from developing self knowledge. The transition period may also lead to great upheaval, marriage dissolution, alcoholism, or severe depression, without any realization of the influence of work role on these *symptoms.* In fact, often during this upheaval the only thing that is going right is the work. If transition is accepted, the work myth is dismantled and more realistic meaning of work is gained. If understood, the transition can be dealt with (although sometimes with great difficulty) resulting occasionally in dramatic career changes, eg, a banker to carpenter, or in very little change, because understanding was what was needed, not dramatic change.

Changing Role of Women

The changing role of women is having a distinct influence on families and work situations. Although the data on these issues are just being identified and analyzed and definitive statements are lacking, it is important to examine this problem to try to obtain some understanding. What will occur as fewer and

fewer women are socialized to the old concepts of the woman's role, and whether women will suffer many of the same work-related traumas and stresses as men, remains to be seen.

Three important issues are these: 1) Although most of what we read today indicates a different socialization pattern for women, women in the midlife for the most part have been socialized to be dependent rather than independent. 2) The women who are currently in midlife put a different value on work than men. 3) Women have many issues that are either nonexistent or less important for men that significantly effect the midlife transition period.

The midlife issues related to biological changes will not be discussed. They include the influence of society's unrealistic emphasis on young being beautiful, and menopause. Another important issue is that of children leaving the home. Although not dealt with in this paper, these issues are of great importance and must be considered in problem solving.

Today's woman who has reached midlife usually has been socialized for many years toward the need of a man as a protector. To reach success one uses attractiveness and helplessness; one marries success. This obviously has been challenged by the feminist movement. Although the challenge is intellectually accepted by many women, the inner conflicts based on socialization to a role remain. A woman who in midlife loses a spouse through death or divorce commonly has the fear of not being able to survive the hazards of life — economics, paying bills, getting the car fixed, changing the plug on the vacuum, while men describe the loss of comfort, of being cared for.

Many researchers have described the woman's struggle to regain the independence (some use the term power) which has been relinquished to or usurped by a man. A woman's midlife transition period is a time where the need for independence, for realization of her psychodynamic self and the need for maximizing her capabilities or talents come to the fore. This seems to be independent of whether a woman's career at this point is within or outside the home.

Again, as for men, if the conflicts of this period are kept to the unconscious, an inner battle in a woman is waged which causes depression, anxiety, unexplained behavior, and psychosomatic complaints which are frequently accompanied by open conflict with children, husband, friends, and work. A woman who has spent 20 years without a career, who now desires to move in a new direction, may experience a feeling of lost time, of being held back. Many place blame on their husbands, who have fulfilled the protector role. Suddenly it is all changed. A woman may feel the need to go beyond her own freedom and to gain power over her spouse, or she may require approval of her husband. Obviously freedom is not gained if a woman must ask for power that the man never rightfully had. When freedom is finally realized, anger is frequently increased, unless understanding is gained about the roles of both partners in creating the current situation.

The Childless Woman

Another important midlife situation is the childless woman. Many women who have not had children because of career choices, remaining unmarried, or for medical reasons seem to go through a period of mourning or loss. Actually a similar feeling of loss has been described in women who have children, when they reach the non childbearing ages. Again, depression, anxiety, somatic complaints, and decreased productivity are common.

Although there are many exceptions, women don't tend to overestimate the importance of work. The magical payoff for women that gets destroyed in midlife is the homemaker role. Entering the job market for most women requires balancing home responsibilities with job responsibilities. There is the difficulty of obtaining jobs with status and high pay even when deserved by demonstrated abilities. Even the most talented seem to experience fear of being able to achieve success at work after any prolonged period of absence from the job market.

Women do, however, have far more peer and social support for entering, leaving and reentering the job market and for career change than men. Career counselling services are far more available to women than men. The issue of what type of career to pursue after divorce or widowhood becomes an important issue, not only because of economic necessity, but also because of the psychodynamics and personal career needs involved in

these decisions. The complexities of this type of situation can be illustrated by a case of a woman in her thirties following the loss of her husband in a work accident when a wall collapsed. Her initial responses included the feeling of loss, being alone, how will I manage? plus *anger* about being left with a young child and 7 months pregnant. These feelings were coupled with guilt that she had insisted on a certain standard of living that led her husband to work in construction rather than at teaching school. Six months later, she has begun to talk about a career; how she never used her masters degree; and particularly that the career choice must be self-satisfying and allow her to develop talents that she feels are in a different direction from her formal education. Feelings that she had before her husband died of being closed in, unable to pursue her own interests, for which she felt guilty at the time of his death, have surfaced. The midlife transition has been precipitated by a crisis. She needs to know about the normal developmental stages she is experiencing.

Changing Understanding of Adult Development

This paper has only scratched the surface of a new and rapidly changing understanding of adult development that individuals and health practitioners must add to their expertise. I hope that what has been discussed will provide a feeling for the dynamics of midlife transition and particularly its effect on work and traditional family roles. This knowledge is needed better to identify and deal with one's own role, as well as one's patients' developmental problems. In the future, it will be appropriate to teach normal adult development, just as child development has been taught in medical schools for years.

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III. Family Stress and the Physician

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The family appears to be in a state of crisis. The divorce rate has doubled over the last twenty years. The decline in birth rate to 1.8 per woman in 1977 was below replacement for our population. Parents are frustrated, and some young people say they do not plan to have children. As physicians, we have an important role to play in helping our patients gain perspective on their family lives.

If we examine the facts, however, we find that the family really is a supportive institution for both adults and children today[1]. The 1977 United States Bureau of the Census data[2] show that most children live with their parents and, except for 3 per cent, have a parent immediately available to them. Seventy-nine per cent live with two parents, and 66 per cent live with both of their original parents. Eighteen per cent live in single parent homes.

We hear that mobility is more prominent in family life today than it was in the past. A study of an ethnic area of Boston in the 1850s, however, found that only 30 per cent of the families were there at the beginning and at the end of a ten year period. Although greater today in terms of distance, family mobility has been part of life over the history of Western civilization, particularly during the Industrial Revolution in England, the frontier days of the United States, and the waves of European emigration.

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widowers chosen from the death certificates and seen at 1 month, 4 months, and 13 months after the deaths of their spouses. The third sample[4] was a consecutive series of young (under 45 years old) spouses also seen within one month and then again at one year. The last two samples were matched through the voter registry with married people of the same age and sex who are also followed prospectively to ascertain the morbidity and mortality of a normal control group.

The findings confirm that bereavement produces a normal depressive reaction. In the first month the large majority of the sample experienced depressed mood, anorexia and beginning weight loss, insomnia that was initial, middle and terminal, marked crying, some fatigue and loss of interest in their surroundings, but not necessarily the people around them, restlessness, and guilt. The guilt that these people expressed was very different than that seen in the depressed patient. It was the guilt of omission chiefly surrounding the terminal illness or death. "Why didn't I stay with him the night he died?" "Why didn't I talk to him in the ambulance?" "Why didn't I get him to a doctor sooner?" Irritability was common, but overt. Anger was uncommon. When questioned, the anger centered most frequently on the deceased with such things as "Why didn't he go to the doctor sooner?" or "Why didn't he stop drinking or smoking?" or on the physician, hospital, or nurses. The anger that was expressed seemed very specific and appropriate. Suicidal ideas were rare. They were more common in younger men and women after the death of a child or perhaps young men after the death of a spouse, but for the large population it was unusual for people even to entertain suicidal ideas much less express them. Hallucinations were not uncommon. Many widows and widowers, when asked, admitted that they had felt touched by their dead spouse or had heard his voice, had a vision of him, or had smelled his presence.

About half the bereaved population took some kind of hypnotic or tranquilizer in the first month, although two-thirds of them had used these drugs before. So, for the most part, physicians did not prescribe drugs for the first time to the recently bereaved. The bereaved experienced a few physical symptoms, mainly of anxiety type such as palpitations, breathlessness, chest pains, and choking, but for the most part their health was very little changed.

These symptoms were as frequent in men as in women, in people who had lost a spouse suddenly or after a lingering illness, in people who have had good or bad marriages, or in religious and nonreligious people.

Symptoms that differentiate normal bereavement from depression are inappropriate hostility, morbid ruminative guilt, expressed suicidal ideas, and psychomotor retardation. Agitation and restlessness are common, but retardation has never been reported in a case of normal bereavement.

It is not uncommon for a normal widow or widower to lose up to 20 lbs. About three to four months after the bereavement most people regain their appetite and begin to gain weight. In the same way, sexual interests are renewed. The only persisting symptom besides intermittent crying and low mood, especially prominent on holidays, birthdays, and anniversaries, is insomnia. Even at one year over half the people still had significant insomnia. By one year 85 per cent of the people are functioning back at their normal level, but 15 per cent are still depressed. The best predictor of depression at one year is being depressed at one month. That is, delayed grief is rare, and those people who are doing poorly at one year can usually be recognized at one month.

In the bereavement period, from all studies, there is an increase in alcohol consumption, smoking, and drug use. Because of this, drugs should be prescribed cautiously and for limited time periods. From all studies in the literature, the best predictor of outcome is previous physical and psychiatric health; that is, those people who have had poor physical health are more likely to see a physician and to do worse in the year following bereavement. This may explain the mortality associated with bereavement. In the same way, those people who had psychological disorders prior to the bereavement are more likely to express and experience psychiatric distress following a bereavement. This is particularly true for the alcoholic. He drinks heavily, misses work, misses eating, may be admitted to a medical or psychiatric hospital, and has an increased suicide rate in the first six months following the death of someone close.

In reviewing the literature as well as in comparing our bereaved with their controls, it is clear that there is minimal physical distress

in the first year of bereavement besides that which is already outlined. For the most part, there are no increased medical or psychiatric hospitalizations. Mortality rates for women do not change and probably do not change for young men. Men over the age of 55 do have an increased mortality rate in the first year following the death of a spouse.

I would like to end by saying a word about "good grief." It is a phrase that I have used in the past, borrowed from Charlie Brown, because I wanted to imply that grief was not, to most people, as devastating and disastrous as the literature would lead us to think. However, I have given up the term. Having followed all these men and women, some of whom still call and tell me what is happening in their lives, I think that grief is a very hard thing to pass through. It is hard to make it a growing experience and to think of it as "good". It is only after a long time that most of these people can look back and say, "Well perhaps there were some positive things about it." As physicians, we should be sensitive to the psychological distress and treat it conservatively when indicated.

References

1 Freud S: Mourning and melancholia (1917), in The Complete Psychological Works of Sigmund Freud, XIV. London, Hogarth Press, 1957, pp 243-258.
2 Clayton P, Desmarais L, Winokur G: A study of normal bereavement. Am J Psychiatry 125 (2):168-178, Aug 68.
3 Clayton PJ, Halikas JA, Maurice WL: The bereavement of the widowed. Dis Nerv Syst 32 (9):597-604, Sep 71.
4 Clayton PJ, Darvish HS: Course of depressive symptoms following the stress of bereavement, in Barrett JE, et al: Stress and Mental Disorder. New York, Raven Press, 1979, pp 121-136.

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V. The Magnitude of Depression in the Community

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Jerome K. Myers, PhD

The topic for this presentation is the magnitude of depression in the community—who is being treated, by whom, how, and to what extent? Let us begin by answering these questions.

The magnitude of depression in the community is great. Depression is the most common psychiatric disorder. The majority of depressed persons are being treated. The treatment they receive for depression however, is minimal; most often they are treated for nonspecific somatic complaints.

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Nature of the Study

Our information derives from two sources: a study of an urban community, and observations of patients under care for depression.

The Community Sample. The community sample derives from a survey of New Haven, Connecticut, conducted in 1976 at Yale University. This study included interviews with more than 500 persons ranging in age from 26 to 89 years, who lived in a defined neighborhood in New Haven and represented a broad spectrum of social classes, education, and ethnic backgrounds.[1]

The Patients. The patient sample derives from long-term follow-up studies of persons treated at the Yale University Depression Research Unit.[2] These patients were part of clinical studies testing the efficacy of drugs and psychotherapy for depression.[3-5] Patients were followed up one year and four years after their treatment had ended in order to determine their clinical course and the treatment they received when they were no longer under our care.

Let's begin by describing what we mean by depression.

Depression as a Clinical Syndrome. In this discussion we are concerned with depression as a clinical syndrome, which includes a number of specific symptoms of certain severity and persistence that produce impairment, or disability, or both and occur in the absence of other symptoms or disorders that may better explain the condition.

Table 1 shows the Research Diagnostic Criteria (RDC) for the syndrome of major depression. This includes dysphoric mood, at least five other symptoms, persistence of at least two weeks, producing impairment of functioning or necessity of treatment, and occurring in the absence of schizophrenia or other disorders which may better explain the symptoms. There are further subclassifications of the depressive syndrome (eg, unipolar, bipolar, primary, secondary) which are of considerable research and therapeutic significance but are not critical for this discussion.

Results

Magnitude of the Problem. The current prevalence rate of depression in the community was 3.7 per cent. The rates were highest among women, persons not currently married, and the older age groups. The rate for bipolar disorder (ie, persons who experience both depression and manic states) was considerably lower — 1.2 per cent. Nearly

Table 1. Research Diagnostic Criteria (RDC) for a Depressive Syndrome[7]

A through F required for the episode of illness being considered.

A. Dysphoric mood which is prominent and relatively persistent.

B. At least 5 of the following symptoms are required for definite:
   1) Poor appetite or weight loss or increased appetite or weight gain.
   2) Sleep difficulty or sleeping too much.
   3) Loss of energy, fatigability, or tiredness.
   4) Psychomotor agitation or retardation.
   5) Loss of interest or pleasure in usual activities, or decrease in sexual drive.
   6) Feelings of self-reproach or excessive or inappropriate guilt.
   7) Complaints or evidence of diminished ability to think or concentrate, such as slow thinking, or mixed-up thoughts.
   8) Recurrent thoughts of death or suicide, including thoughts of wishing to be dead.

C. Dysphoric features of illness lasting at least 2 weeks.

D. Sought help from someone during the dysphoric period or had impaired functioning.

E. None of the following which suggests schizophrenia is present:
   1) Delusions of being controlled, or of thought broadcasting, insertion, or withdrawal.
   2) Non-affective hallucinations of any type throughout the day for several days or intermittently throughout a one-week period.
   3) Auditory hallucinations in which either a voice keeps up a running commentary on the subject's behaviors or thoughts as they occur, or two or more voices converse with each other.
   4) At some time during the period of illness had more than one month when he exhibited no prominent depressive symptoms but had delusions or hallucinations.
   5) Preoccupation with a delusion or hallucination to the relative exclusion of other symptoms or concerns.
   6) Definite instances of marked formal thought disorder, accompanied by either blunted or inappropriate affect, delusions or hallucinations of any type, or grossly disorganized behavior.

F. Does not meet the criteria for Schizophrenia, Residual Subtype.

This work was supported in part by US PHS grants #1 R01 MH25712, #1 R01 MH28274, and #1 R01 MH26466, from the Center for Epidemiologic Studies and the Clinical Research Branch, National Institute of Mental Health; Alcohol, Drug Abuse and Mental Health Administration (ADAMHA), Rockville, Maryland. The clinical study was conducted in collaboration with Gerald L. Klerman, MD, Alberto DiMascio, PhD, Eugene S. Paykel, MD, and Brigitte A. Prusoff, PhD.

half of the persons with a depression had received other psychiatric diagnoses at some time in their lives, most commonly alcoholism and anxiety.

How Many Depressives Are Being Treated? Few persons with a diagnosable depression were being treated for problems they identified as emotionally related. In our community sample, only 34 per cent of such persons had received treatment from any professional, including psychiatrists, nonpsychiatric physicians, psychologists, social workers, nurses, or clergy.

Who Is Treating the Depressive for an Emotional Problem? Only 6 per cent of the depressives were hospitalized; 17 per cent received outpatient care with a mental health professional; 9 per cent received outpatient care with a nonpsychiatric physician; and 14 per cent received treatment with other professionals. Only 6 per cent saw a psychiatrist.

What is the Utilization of the General Health Care System? Persons with a depression were high users of the general health care system, ie, of those with a current depression, 72 per cent saw a nonpsychiatric physician four or more times during the year. These visits were not identified as being for an emotional problem. Only 6 per cent of the depressives did not visit a physician.

What Treatment Do They Receive? There were 35 per cent of persons with a depression who received minor tranquilizers (Librium® or Valium®). Only a small number (17 per cent) received antidepressants.

Depressives from a Clinic Population. The results shown thus far derived from a community survey. Confirming data are available from follow-up studies of depressed outpatients who had received maintenance tricyclic antidepressants for eight months with or without psychotherapy as part of a controlled clinical trial. The follow-up is of particular interest because all of these patients responded to tricyclic antidepressants. These patients were followed one year and four years after the controlled maintenance treatment had ended, when they were no longer under the care of the research clinic. We were interested in their clinical course and the treatment they had received elsewhere. The results were essentially similar to what we found in the community study. Most patients did not see a psychiatrist; most received minor tranquilizers; and their recurring depressions were not diagnosed after they left our clinic.

Long-Term Clinical Course and Treatment Received. After maintenance treatment ended, 28 per cent of the patients had been in complete remission over one year, 60 per cent had a return to moderate symptoms, and 12 per cent had chronic mild symptoms.

Attention focused on the 12 per cent who were chronically symptomatic. Chronically depressed patients can pose diagnostic and treatment challenges, and can be high users of medical services. Their persistent somatic complaints often lead to costly laboratory and x-ray procedures. If these diagnostic studies are negative, such patients are considered troublesome and are labelled "neurotic" or "crocks." Many hypochondriacal patients are in fact unrecognized and poorly treated depressives.

In a closer follow-up examination of the treatment received by these chronic patients, we found the following: the chronic patients sought treatment more frequently than other patients, often from their family physicians, outpatient medical clinic, or hospital emergency room, rather than from mental health professionals. However, the treatment they received tended to be sporadic. They frequently received minor tranquilizers. Only about 25 per cent of the former patients received a tricyclic antidepressant.

Conclusion

The magnitude of untreated depression in the community, in the general physician's office, and in the practice of mental health professionals is high. Depressives are high utilizers of nonpsychiatric physicians for nonpsychiatric reasons. Very few depressives identify or acknowledge having an emotional problem and even fewer see a mental health professional. Few receive tricyclic antidepressants. Most depressives receive no pharmacotherapy, and no psychotherapy, and, when they do receive treatment, it is minor tranquilizers.

Failure of the clinician to recognize depression as a diagnosis may be coupled with extensive reliance on minor tranquilizers and other sedative-hypnotic agents. In contrast, the tricyclic antidepressants are probably underutilized, and there is a discrepancy between the findings of clinical trials and prescription practices in these patients.

Data from the study of Covi-Lipman, et al[6] cast doubt as to the efficacy of maintenance minor tranquilizers for the long-term treatment of depression. This study, which involved a sixteen-month trial of imipramine, diazepam, or placebo in a sample of depressed outpatients, presented strong evidence for the efficacy of the tricyclic antidepressant over diazepam or placebo beyond the first two to four weeks. Moreover, data from our New Haven-Boston Collaborative Depression Maintenance Trial, as well as from three other independent maintenance trials, have shown the superiority of tricyclic antidepressants over placebo or no pill in preventing relapse and symptom return in depressed patients.[3-6]

Part of the discrepancy between research evidence and clinical practice may be associated with limited access to treatment and patients' acceptance of treatment for psychiatric problems, but this can be only a small part since the data showed that the depressed persons did use the health care system. Therefore, it is incumbent upon the nonpsychiatric physician and health professional to learn how to detect depression in patients appearing at the medical facility, how to treat it properly, and when to refer the patient for specialized psychiatric treatment.

References

1 Weissman MM, Myers JK: Affective disorders in a United States community: the use of research diagnostic criteria in an epidemiologic survey. Arch Gen Psychiatry 35:1304-1311, Nov 78.

2 Weissman MM, Klerman GL: The chronic depressive in the community: unrecognized and poorly treated. Compr Psychiatry 18:523-532, Nov-Dec 77.

3 Klerman GL, DiMascio A, Weissman MM, et al: Treatment of depression by drugs and psychotherapy. Am J Psychiatry 131:186-191, Feb 74.

4 Weissman MM: Psychotherapy and its relevance to the pharmacotherapy of affective disorders: from ideology to evidence, in Lipton M, DiMascio A, Killam K (eds): Psychopharmacology—A Generation of Progress. New York, Raven Press, New York, 1978, pp 1313-1321.

5 Klerman GL: Combining drugs and psychotherapy in the treatment of depression, in Greenblatt M (ed): Drugs in Combination with Other Therapies. New York, Grune & Stratton, 1975, pp 67-81.

6 Covi L, Lipman R, Derogatis L, Smith J, et al: Drugs and group psychotherapy in neurotic depression. Am J Psychiatry 131:191-198, 1974.

7 Spitzer R L, Endicott J, Robins E: Research diagnostic criteria: rationale and reliability. Arch Gen Psychiatry 35:773-782, 1978.

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VI. Management of Suicidal Behavior

Herbert C. Modlin, MD

In the United States suicide is tenth among leading causes of death, third in the 15-19 age group, and second on the college campus. Suicide may be considered the first and leading cause of unnecessary and stigmatizing death.[1]

Public records indicate about 22,000 suicides a year, a ratio of 10.5 per 100,000 population. The actual number is thought to be two or three times greater, probably 50,000. The final mortality statistics reported for 1976 by the National Center on Health Statistics show that the nation's death rate is at an all time low — 8.9 deaths per 1,000 population. Of the fifteen leading causes of death, the rates for thirteen went down compared to the previous year. Only two causes showed an increase — cancer and suicide.

Suicide may be viewed as a public health problem, as are highway accidents. The public health model is seldom relevant in

Herbert C. Modlin, MD, *Professor of Forensic Psychiatry, The Menninger Foundation, Topeka, Kansas.*

office practice with individual patients; but the evaluation of suicidal probability may be an exception. The patient rarely presents himself with overt complaints that he is considering suicide. The doctor's capacity to ferret out the possibility depends on his ability to form clinical inferences from direct evidence. Once a set of cues is detectable from standard data obtained by the office or hospital clerk or nurse — age, sex, marital status, living arrangements, race, employment, and physical health — the data recorded under those headings can be used to identify a high risk group.

Identifying the Suicide Prone

1. *Age.* The suicidal rate increases each decade. The incidence of suicide rises significantly after age 45.

2. *Sex.* Three out of four successful suicides are accomplished by males. In contrast, three out of four attempts by females are unsuccessful. Several reasons for this difference have been suggested: (1) Men in our culture tend to keep their problems to themselves and are reluctant to seek help, so that they more often reach a stage of lonely desperation; (2) women may resort to a suicidal attempt as a demonstration of distress and a call for help; (3) men more commonly shoot themselves while women use overdoses of drugs, a slower acting method which allows for a rescue period.

3. *Marital status.* There is an increasing suicidal rate along the continuum married-single-widowed-divorced.

4. *Living arrangements.* He who lives alone is the more vulnerable in that he has relatively few psychological supports available in times of despondency. The widower or male divorcee living in a boarding house should be considered particularly suspect.

5. *Race.* The suicidal rate of whites is about five times that of blacks. This figure may be changing, since there is some evidence that the suicide rate among blacks rises as they achieve upward social mobility and middle class status.

6. *Employment.* The unemployed are many times more prone to self-destructive behavior than the gainfully employed. A job usually provides psychological structure, meaningful contact with fellow human beings, income security, and self-esteem.

7. *Physical health.* Most studies of successful suicides emphasize the frequency of known, diagnosed physical illness. The rates vary from a low of 45 per cent to a high of 70 per cent in different reports.[2] For most, the chronic nature of their illnesses apparently contributes to their feelings of despair and worthlessness.

To recapitulate, the patient at maximum risk for suicide is an older, white, divorced, unemployed male who lives alone and is in poor health. Several of these conditions coincidentally in a patient should alert the concerned clinician.

Another set of cues appears during the course of a medical interview and initial examination of the patient; the two most telling are depression and alcoholism.[3] Emotional depression, with concomitant slowing of thought processes and psychomotor retardation, is the one most predictive clinical signal of suicidal potential. A summary of seventeen studies of affective disorders revealed suicidal rates varying from 12 to 60 per cent in various patient groups.[4] The average rate is thirty times greater than exists in the general population. Retrospective studies of the lives of successfully suicidal patients report rates of clinically diagnosable depression varying from a low of 50 per cent to a high of 100 per cent.

The depressive syndrome is presumably well known to most physicians. Still, in one recent study the average physician's ready awareness of the syndrome was questioned.[5] In this study of 21 successful depressive suicides, all of the patients had been seen by physicians and only one was on anti-depressive medication. And worse, sixteen were on pro-depression medication — barbiturates, tranquilizers, or both. This prescribing pattern suggests that many physicians pay more attention to anxiety than to depression when the symptoms occur together.

Suicidal Potential of the Depressed

Although the suicidal potential of depressed patients is high, the majority of depressed patients do not attempt suicide. There are several categories of depression, not all of them of equally high risk. Of great importance is the evaluation of hopelessness in the patient's demeanor and verbal productions.[6] Hopelessness is a negative evaluation of the future, a conviction that there are no alternatives. There is a highly significant posi-

tive correlation between the level of hopelessness and the seriousness of suicidal intent. Hopelessness has a high lethality index.

Chronic alcoholism frequently leads to progressive physical, social, and psychological deterioration. Common accompaniments are social disorganization, marital failure, job jeopardy or loss, and physical ill health. A severely lessened self-esteem results; a profound sense of worthlessness sets in; and life becomes an item of low value.

In evaluating the lethality potential in a depressed patient, assessment of the degree of hopelessness and the ravages of alcohol are important clinical considerations. A third closely related factor is the degree of alienation or social isolation. The isolated person by definition has few resources for help either in his environment or in himself when stresses threaten to overwhelm him. The physician, minister, welfare worker, or skidrow mission thus become the only potential sources of help he can identify. If they fail him he can perceive no alternatives to suicide in an intolerable situation.

Specific clues to suicide are manifest in a patient's behavior. A common fallacy in the mythology of suicide is that a person who talks of suicide will not commit it. Numerous studies document that 60-80 per cent of suicide victims have stated their intentions beforehand.[7] A related fallacy is that suicide happens without warning.[8] On the contrary, it is usually entertained and planned over a period of time. Homicide is frequently impulsive, suicide almost never. In one study of 134 successful cases, 41 per cent of the victims had previously stated their intentions of killing themselves, 24 per cent had stated that they would be better off dead or were tired of living, 22 per cent had expressed a desire to die, and 22 per cent had made a previous overt suicidal attempt. As a matter of interest, those communications were transmitted to spouses in 60 per cent of the cases, relatives 51 per cent, friends 35 per cent, and physicians 18 per cent.

The most obvious and useful clue is a prior suicidal attempt. In various clinical studies, from 25-60 per cent of persons who have killed themselves attempted to do so previously.[9] The suicide rate among those who have previously attempted suicide is 64 times higher than that of the general population.[10]

The problem of self-destruction has ever been with us. A society not plagued by it is hard to imagine. Considering the ubiquity of suicide, one might lean toward accepting it as an inevitable phenomenon, but the practicing physician cannot comfortably maintain that attitude once he shifts his focus from statistical data to the individuals concerned. Upon viewing suicide retrospectively as the outcome of a personal crisis, one cannot suspect that most, if not all, suicides are indeed not inevitable. Through unflagging clinical vigilance to pick up cues and clues, to interpret them accurately, to institute measures of help and intervention promptly and forcefully, physicians can extend their lifesaving capabilities into the suicidal arena and can sometimes forestall a tragic death.

References

1 Yolles S: Suicide: a public health problem, in Resnik HLP (ed): Suicidal Behaviors. Boston, Little Brown, 1968.
2 Ripley HS: Suicidal behavior in Edinburgh and Seattle. Am J Psychiatry 130:995-1001, Sep 73
3 Schukit MA, Gunderson E K E: Suicide in the naval service. Am J Psychiatry 131:1328-31, Dec 74
4 Guze SB, Robins E: Suicide and primary affective disorders. Br J Psychiat 117:437-8, Oct 70.
5 Motto JA: Toward suicide prevention in medical practice. J JAMA 210:1229-32, 17 Nov 69.
6 Minkoff K, Bergman E, Beck AT, et al: Hopelessness, depression and attempted suicide. Am J Psychiatry 130:455-9, Apr 73.
7 Williams M: Risk-taking and suicide, in Lieberman J (ed): Mental Health: The Public Health Challenge. Washington, American Public Health Association, 1975.
8 Pokorney A: Myths about suicide, in Lieberman J (ed): Mental Health: The Public Health Challenge. Washington, American Public Health Association, 1975.
9 Patel NS: Attempted and completed suicide. Med Sci Law 14:273-9, Oct 74.
10 Pederson AM, Arvad GA, Kindler AR. Epidemiological differences between white and non-white suicide attemptters. Am J Psychiatry 130:1071-76, Oct 73.
11 Stengel E: Suicide and Attempted Suicide. Boston, Penguin, 1965.
12 Rockwell DA, O'Brien W: Physicians' knowledge and attitudes about suicide. JAMA 225:1347-9, Sep 73.

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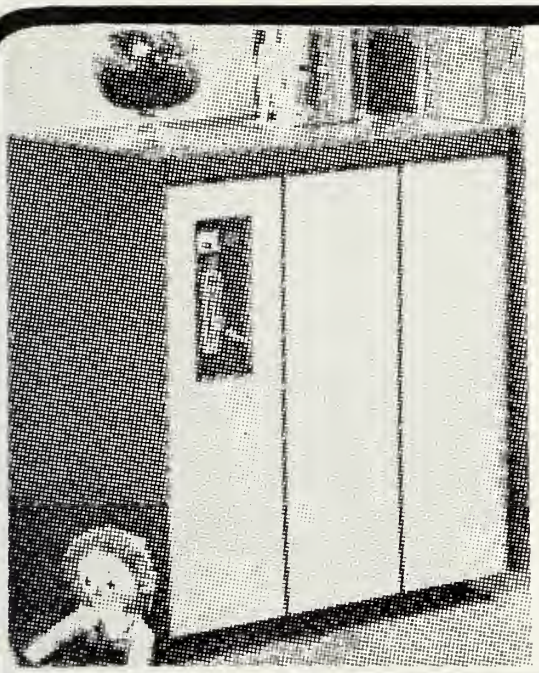

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Rhode Island Medical Society Necrology — 1979

Earle H. Brennen, MD

Doctor Earle H. Brennen died in February, 1979, at 80 years of age. He was a 1917 graduate of Brown University, a 1922 graduate of Tufts College, and served both his internship and his residency at the Boston City Hospital. He was a World War II veteran, a major in the Medical Corps of the Rhode Island National Guard, and a member of the Providence Medical Association, the Rhode Island Medical Society and the American Medical Association. Doctor Brennen was the husband of Margaret G. Brennen.

Frank B. Cutts, MD

Doctor Frank B. Cutts, retired Providence physician, died on August 22, 1979, at 72 years of age. He was a 1924 graduate of Moses Brown School, a 1928 graduate of Harvard University, and he earned his medical degree at Harvard Medical School. During World War II, Doctor Cutts was a lieutenant-colonel and a chief of the medical service. He was the retired director of cardiology at Rhode Island Hospital and former president of the New England Cardiovascular Society, the Rhode Island Medical Society and the Rhode Island Hospital Staff Association. He was the husband of Ann Cutts.

James P. Deery, MD

Doctor James P. Deery, retired physician, died on May 16, 1979, at 72 years of age. Before retirement he was chief of the Rhode Island State Department of Health's Division of Occupational Health. He was educated at La Salle Academy and Providence College, and graduated from Georgetown University School of Medicine in 1932. After his internship at St. Joseph Hospital, he studied at the University of Chicago's Lying-In Hospital. In 1936 he was a resident physician at Forsythe County Hospital, Winston-Salem, North Carolina. He returned to Providence in 1937, when he became affiliated with the Rhode Island State Department of Health. Doctor Deery was a member of the Providence Medical Association and the Rhode Island Medical Society.

David J. Fish, MD

Doctor David J. Fish, Providence psychiatrist, died on May 3, 1979, at 71 years of age. Doctor Fish was chief of the department of neurology and psychiatry at Miriam Hospital from 1955 to 1966, and at Rhode Island Hospital from 1967 to 1969. He was chief of the department of psychiatry at Rhode Island Hospital from 1969 to 1976 and president of its medical staff association in 1969 and 1970.

He was a charter Fellow in the American College of psychiatry, a Fellow of the American Psychiatric Association and the Walter Fernald School, and a member of the American Medical Association, the Rhode Island District branch of APA, the Providence and Rhode Island Medical Societies, the Association for Research in Nervous and Mental Diseases, and the Boston Society of Neurology and Psychiatry.

During World War II Doctor Fish was an Army major, serving as chief of the department of psychiatry and neurology at the Waltham Regional Hospital. He received his bachelor of arts degree from Brown University in 1935, and his medical degree from Jefferson Medical College, Philadelphia, in 1939. He interned at the Charles V. Chapin and Rhode Island Hospitals, Providence, and at Worcester City Hospital, Worcester. His residencies were at the State Hospital of Mental Diseases at Howard. From 1963 to 1965 he taught at the Rhode Island Medical Center. Doctor Fish was the husband of Vera Fish.

William H. Foley, MD

Doctor William H. Foley died on December 28, 1979, at 79 years of age. Doctor Foley was a graduate of Classical High School in 1918, Holy Cross College in 1922, and from Harvard Law School in 1926. He received his medical degree from Boston University Medical School in 1935. He also attended the Colorado School of Mines in 1923. He interned at Roger Williams General Hospital from 1936 to 1938, was a resident in psychiatry at the former Charles V. Chapin Hospital, and held a fellowship at the International College of Surgeons in 1953 while studying at the University of Chicago Medical School. Doctor Foley was a member of the Rhode Island Medical Society, the Providence Medical Association, the American College of Surgeons and the Rhode Island Bar Association. He was the husband of Ruth Foley.

Russell P. Hager, MD

Doctor Russell P. Hager died on April 7, 1979, at 66 years of age. Doctor Hager was a specialist in internal medicine in Warwick for 29 years. He served on the staffs of Kent County Memorial Hospital, Rhode Island Hospital and Butler Hospital, was chief of medicine at Kent County Memorial Hospital between 1951 and 1966, and was also chief of medicine at St. Elizabeth Home and a physician at Steere House. He was president of the Rhode Island Society of Internal Medicine, a past president of the Diabetes Association of Rhode Island, and was chairman of medical education at Kent County Memorial Hospital. He taught at Tufts University, the University of Illinois, the University of Pennsylvania, the University of New Hampshire, and the United States Air Force School of Aviation Medicine. He was a veteran of the Army and retired as a captain.

Doctor Hager was a member of the American College of Physicians, the American Society of Internal Medicine, the Rhode Island Society of Internal Medicine, the Kent County Medical Society, the Rhode Island Medical Society, the American Geriatric Society and the American Medical Association.

He was the husband of A. Marion Hager.

Cyril Israel, MD

Doctor Cyril Israel of Woonsocket died April 5, 1979, at 79 years of age. He was graduated from Dean Academy in 1917, from Worcester Polytechnic Institute in 1921, and received his medical degree from Boston University in 1926. He opened his office in Woonsocket and continued to work in that office until retirement. He was a member of the Woonsocket Hospital, served as president of the hospital's medical staff association for several years, and was a member of the Woonsocket District Medical Society and the Rhode Island Medical Society. Doctor Israel was the husband of Ida Z. Israel.

Luther Lewis, MD

Doctor Luther R. Lewis, former Riverside physician, died March 18, 1979, at 67 years of age. He was a 1930 graduate of the East Providence High School, a 1935 graduate of Brown University, and a 1939 graduate of Harvard Medical School. He was a member of the Rhode Island and the Providence Medical Societies, the Obstetrical-Gynecological Society of New England, and was on the staffs of Rhode Island Hospital and Women and Infants Hospital. He was a medical officer in the Army during World War II, and had been a member of the Riverside Post, American Legion. Doctor Lewis was the husband of Jane Lewis.

Louis D. Lippitt, Jr., MD

Doctor Louis D. Lippitt, Jr., died on June 9, 1979, at 71 years of age. Doctor Lippitt was a graduate of Brown University, class of 1930, and the Hahnemann Medical College, Pennsylvania, class of 1934, and he interned at the former Homeopathic Hospital until 1935. He was a member of the Providence and Rhode Island Medical Societies. He was a World War II Army veteran, serving as a medical officer in the China-Burma-India theater, retiring as a Major. Doctor Lippitt was the husband of Louise Lippitt.

Edward R. Maher, MD

Doctor Edward R. Maher, practicing physician in Warwick, died in February of 1979, at 50 years of age. Doctor Maher was a graduate of Providence College in 1952 and from New York Medical College in 1956, and he served his internship and residency at St. Joseph Hospital. He was in the United States Marine Corps from 1946 to 1948. Doctor Maher was a member of the Kent County Medical Society, the Rhode Island Medical Society and the American Medical Association.

John M. Malone, MD

Doctor John M. Malone died on September 4, 1979, at 65 years of age. He was a 1937 graduate of Rhode Island State College, received his medical degree from the Vanderbilt University School of Medicine in 1941, and served internships at Rhode Island Hospital, Lying-In Hospital and Charles V. Chapin Hospital, Providence. He was an Army veteran, serving as a surgeon with the 760th Tank Battalion during World War II. He was an active staff member and chief of the Department of Anesthesiology at Newport Hospital from 1948 to 1975. From 1958 to 1966 he was a member of the Council of the Rhode Island Medical Society. He was a member of the American Medical Association, and the Rhode Island, New England, American and International Societies of Anesthesiology. Doctor Malone was the husband of Muriel Malone.

Mathew W. Rossi, MD

Doctor Mathew W. Rossi died on February 3, 1979, at 62 years of age. He had graduated from LaSalle Academy and Providence College and received his medical degree from Georgetown University Medical School in 1942. He retired from general practice in 1976. He was a member of the American Medical Association and the Rhode Island Medical Society. Doctor Rossi was the husband of Peggy Rossi.

Meyer Saklad, MD

Doctor Meyer Saklad died on July 25, 1979, at 78 years of age. Doctor Saklad received both his premedical and medical training at Tufts University, and served an internship at The Memorial Hospital, Pawtucket, 1924-1925. He was chief of the anesthesiology department at Rhode Island Hospital from 1939 until 1962. His professional affiliations included: president of the American Board of Anesthesiology, the New England Society of Anesthesiologists and the Rhode Island Society of Anesthesiologists, chairman of the American Medical Association's Section on Anesthesiology, member of the Board of Medical Advisors of the American Association for Inhalation Therapy, member of the Brown University Advisory Committee on Minority Student Affairs, member of the Brown University Ad Hoc Committee on Anesthesiology and member of the International Standards Organization. He was also a member of the Providence Medical Association and the Rhode Island Medical Society. Doctor Saklad was the husband of Lillian Saklad.

William J. Schwab, MD

Doctor William J. Schwab, retired Providence surgeon, died on February 20, 1979, at 69 years of age. He was a graduate of Hope High School, attended Providence College from 1929 to 1931, was graduated in 1933 from Georgetown University Medical School, and served internships at St. Francis Hospital, New York City and St. Joseph Hospital, Providence. He was a commander in the Navy from 1940 to 1946. Also, he was a member of the Providence Medical Association and the Rhode Island Medical Society. Doctor Schwab was the husband of Catherine M. Schwab.

James F. Valicenti, MD

Doctor James F. Valicenti died on March 3, 1979, at 43 years of age. He was a 1961 graduate of Adelphi University, studied at Lausanne University of Switzerland for two years and completed his medical education at Duke University in 1966. He was chief of pulmonary services at St. Joseph Hospital, was on the medical staff of Rhode Island Hospital, where he served his internship and residency, and previously had been chief of medical service and associate in clinical and experimental research in the pulmonary division of The Memorial Hospital, Pawtucket. He was a member of the American Medical Association, the Rhode Island Medical Society, the Providence Medical Association, and the Rhode Island Lung Association, and a fellow of the American College of Chest Physicians. Doctor Valicenti was the husband of Patricia T. Valicenti.

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Report of the House of Delegates

A meeting of the House of Delegates of the Rhode Island Medical Society was held in the auditorium of the Society on Wednesday, January 30, 1980.

The meeting was called to order by the Speaker of the House, Dr. Leonard S. Staudinger at 2:15 PM. Members present were:

Officers:
Charles L. Hill, MD, President; Peter L. Mathieu, Jr., MD, President-Elect; Melvin D. Hoffman, MD, Secretary.

Immediate Past President:
Joseph E. Caruolo, MD.

Delegates:
Kent County Medical Society: Peter B. Baute, Klaus F. Haas, Richard W. Perry, MDs.

Newport County Medical Society: Charles P. Shoemaker, Jr., Edwin Singsen, MDs.

Providence Medical Association: Michael S. Barrett, Joseph P. Bellino, Thomas G. Breslin, Alphonse R. Cardi, Erminio Cardi, John J. Coughlin, Frank G. DeLuca, John E. Farley, Jr., Herbert F. Hager, Charles L. Hill, Melvin D. Hoffman, Harry M. Iannotti, Robert A. Indeglia, Betty B. Mathieu, Richard T. McDermott, H. Raymond McKendall, Anthony F. Merlino, Daniel Moore, Jr., Robert W. Riemer, Louis V. Sorrentino, Hugo Taussig, Raymond W. Waggoner, MDs.

Washington County Medical Society: Erwin Siegmund, MD.

Woonsocket District Medical Society: Orazio J. Basile, E. James Monti, Jr., MDs.

Specialty Society Representatives: Rhode Island Society of Internal Medicine, Frank P. Duffy, MD; Rhode Island Section, American College of Obstetricians and Gynecologists, John J. Coughlin, MD; Rhode Island Chapter, American Academy of Pediatrics, John A. Farley, Jr., MD; Rhode Island Branch, American Psychiatric Association, Louis Hafken, MD; Rhode Island Society of Anesthesiologists, Augustine M. McNamee, MD; Rhode Island Association of Emergency Room Physicians, Robert L. Conrad, MD; Rhode Island Ophthalmological Society, Arthur I. Geltzer, MD; Rhode Island Otolaryngological Society, Stephen Issenberg, MD.

Commissioners: Daniel Moore, Jr., Anthony F. Merlino, MDs.

Members Ex Officio: Seebert J. Goldowsky, MD, Editor, *Rhode Island Medical Journal;* Herbert F. Hager, MD, Alternate Delegate, American Medical Association.

Speaker: Leonard S. Staudinger, MD.

Vice Speaker: Charles P. Shoemaker, Jr., MD.

Also Present: Louis Vito, Jr., MD, Chairman, Committee on Self-Insurance; Pasquale J. Celestino, MD; Frank M. D'Alessandro, MD; Robert H. Rosen, MD; Jean K. Ashba, MD; Mrs. Louis Arnow, President, Newport Auxiliary; Karen Challberg, Staff; Howard Lawton, Staff; Jim Clarkin, Staff.

Members absent were:

Officers: Melvyn M. Gelch, MD, Treasurer (excused).

Delegates:

Bristol County Medical Society: Leonard J. Parker, MD.

Kent County Medical Society: James Hagerty, W. A. Van Haaren, (excused), William F. Varr, Jr., MDs.

Newport County Medical Society: George P. Lewis, Jr., MD.

Pawtucket Medical Association: Robert S. Burroughs, Robert E. Curran, (excused) David R. Hallmann, Richard E. Kuhn, Nathan Sonkin, MDs.

Providence Medical Association: Charles J. Ashworth, Jr., (excused) Bernard J. Ber-

stein, George N. Cooper, Jr., Melvyn M. Gelch, (excused), Jerry M. Kheradi, (excused), William S. Klutz, Joseph P. Lombardozzi, (excused), William J. MacDonald, (excused), P. Joseph Pesare, (excused), Henry J. Robidoux, Robert G. Rosenberg, (excused), Guy A. Settipane, (excused), Rajnikant Shah, Richard L. Testa, (excused), Louis F. Torrado, Joseph R. Tucci, MDs.

Washington County Medical Society: Robert E. Knisley, Louis A. Morrone, Douglas A. Rayner, MDs.

Woonsocket District Medical Society: Oscar Z. Dashef, Catello T. Scarano, MDs.

Specialty Society Representatives: Rhode Island Orthopedic Society, A. Louis Mariorenzi, MD; Rhode Island Chapter, American Academy of Family Physicians, Charles E. Millard, MD; Rhode Island Society of Pathologists, Inc., William Q. Sturner, MD; Rhode Island Dermatological Society, Bencel L. Schiff, MD; Rhode Island Society of Allergy, Guy A. Settipane, MD; Providence Surgical Society, George T. Van Pettern, MD; Rhode Island Chapter, American College of Surgeons, Paul J. M. Healey, MD; Rhode Island Society of Neurosurgery, Walter C. Cotter, MD; Rhode Island Society of Nuclear Medicine, Ben C. Claunch, MD; Rhode Island Thoracic Society, John A. Pella, MD.

Commissioners: Donald P. Fitzpatrick, (excused), Kenneth E. Liffmann, George N. Cooper, Jr., MDs.

Members Ex Officio: Joseph E. Cannon, MD, Director, Rhode Island Department of Health; John J. Cunningham, MD, Delegate to the AMA (excused); William J. MacDonald, MD, Board Chairman, Rhode Island Blue Shield (excused).

Approval of the Minutes

The Speaker noted that the minutes of the previous meeting on October 10, 1979 had been printed and distributed by the Secretary.

Action: A motion was made, seconded and voted that the minutes of the regular meeting of the House of Delegates on October 10, 1979 be approved and placed on record.

Report of the Secretary

The Speaker noted that the report of the Secretary was contained in the Handbook and all were of an informational nature.

12) John Schroeder, Vice President of the Johnson and Higgins Company addressed the House relative to the results of the survey to determine the feasibility of forming a physician-owned insurance company. He noted that 605 surveys had been returned, representing 52% of the total mailing. The responses compared favorably with similar surveys his organization had conducted and as in the other cases, the majority in this survey favored formation of a physician-owned company. Two large reinsurance companies have expressed interest in providing this type of coverage if a company is formed.

Mr. Schroeder's presentation was solely to update the Delegates on the progress to date.

In the absence of request for discussion of any other items in the Secretary's report, the Speaker called for a motion to approve the report.

Action: A motion was made, seconded and voted that the Report of the Secretary be approved and placed on record.

Report of the Treasurer

The Secretary noted that the Report of the Treasurer was included in the Handbook.

It was noted that the figure at the end of #1 — Investment Portfolio, $34,362.36 should be corrected to read, — $38,472.49.

Action: A motion was made, seconded and voted that the Report of the Treasurer, as amended, be approved and placed on file subject to audit.

Dr. Charles L. Hill, noting that Dr. Gelch had expressed a wish not to be considered for renomination as Treasurer, stated that he wished to express the Society's appreciation for the superb job Dr. Gelch has done as Treasurer. His suggestions regarding finance, the transfer of funds and investment to a professional management group have improved both the income and quality of the Rhode Island Medical Society. The House of Delegates concurred with this expression by adopting the following:

Action: A motion was made, seconded and voted that a letter be sent to Dr. Gelch congratulating him and expressing gratitude for the achievements attained for the financial betterment of the Society because of his suggestions and actions as Treasurer, and that further, he be requested to reconsider his wish

not to be considered for renomination to the office of Treasurer.

Recommendations from the Council

The Secretary, Dr. Melvin D. Hoffman, presented the following recommendations from the Council and the following actions were taken:

1) *Spring Meeting of the House of Delegates*

Action: A motion was made, seconded and voted to approve the recommendation to hold the Spring meeting of the House of Delegates on Wednesday, March 26, 1980 at 2 PM with adjournment in time to attend the Blue Shield Annual Meeting at 5 PM.

2) *Blue Shield Directors*

Action: A motion was made, seconded and voted that Drs. Paul E. Barber, Richard R. Dyer, Paul J. M. Healey and Leonard S. Staudinger be renominated for appointment as members of the Blue Shield Board of Directors.

3) *Changes in Bylaws*

Action: The House voted to approve the Bylaws changes as listed in the Handbook.

4) *Rhode Island Medical Journal*

Action: A motion was made, seconded and voted to approve the allocation of $11,000 in the 1980 budget for the *Rhode Island Medical Journal* subject to review each year upon request for a specific appropriation.

5) *John Farrell's Pension*

Action: A motion was made, seconded and voted to approve the adjustment made to the pension agreement between the Rhode Island Medical Society and John Farrell as noted in the Handbook.

6) *Blue Shield Advisory Committee*

Action: A motion was made, seconded and voted that Drs. J. Robert Bowen, John P. Grady and Daniel Moore, Jr. be reappointed to the Professional Advisory Committee of Blue Shield.

Benevolence Fund

The Speaker noted that the Trustees of the Benevolence Fund have filed their 1979 financial report for the information of the House.

It was noted that physician contributions during 1979 totaled $9,205.00 and that financial assistance had been extended to eight physicians and/or their families. Additionally payment of Blue Cross/Blue Shield Premiums for five beneficiaries was made.

Appreciation was expressed to all contributors to the fund for their concern and generosity.

Report of the AMA Delegates

Dr. Herbert F. Hager, Alternate Delegate to the AMA House of Delegates reported briefly on the highlights of the AMA House of Delegates meeting December 2-5, noting the AMA's concern relative to decrease in AMA membership and appealed for an intensive membership drive.

Reports of Committees

The Speaker noted that there were committee reports in the handbook for the information of the House, but none called for any specific action by the House.

Action: A motion was made, seconded and voted that the written report of the following committees, as submitted to the House, be received and placed on record: Committee on Aging, CME Committee, Committee on the Medical Aspect of Sports, Mental Health Committee, Publications Committee, and the Committee on Self Insurance.

Dr. Herbert F. Hager, Chairman of the Committee on Standards and Credentials, reported briefly upon the 1980 relicensing procedure which for the first time required submission of a minimum of 60 CME credits, noting that 1826 applications for licensure had been received, of which 1770 licenses were issued.

Resolutions

The Speaker presented a resolution as submitted to the House from Dr. Hugo Taussig:

Whereas, ever since it was put into operation, there have been discriminatory attempts at curtailing coverage for mental illness in the Catastrophic Health Insurance Plan;

Whereas this runs counter to the policy expressed twice before by this House that coverage for mental illness should be on par with any other illness;

Whereas there have been various concerns in regard to the appropriateness and length of treatment and level of care;

Whereas a Legislative Committee is presently reviewing the Catastrophic Health Insurance Plan;

Be it Resolved: That this House reiterates its view that mental illness should be covered by the same benefits as any other illness; subject to similar peer and utilization review as used in all other instances, and that this resolution be forwarded to the Chairman of said Committee and to Governor J. Joseph Garrahy.

A motion was made, seconded and voted to support the above resolution.

New Business

The President, Dr. Charles L. Hill, reported that up to a week ago it appeared there was no need to consider an increase in annual dues. It has become increasingly evident, however, that just keeping up with the State Health System Plan has at this point cost the member organizations of the Voluntary Steering Committee a considerable amount of money. Yet, even this sum is paltry when compared to the approximately $800,000 allocated by the Department of Health to the Health Planners and the Statewide Health Coordinating Council. The realization that our work is not finished when HEW puts its stamp of approval on the final draft causes us to be concerned and conclude that only an increase in annual dues will provide us with the additional monies necessary to monitor implementations of the plan year after year. The documents released by SHCC are to the average individual complex, highly statistical in nature and difficult to interpret. We need to engage on a year to year basis, a competent professional in health planning to review these documents, provide counseling and submit alternative proposals, when necessary.

We propose, therefore, an increase of twenty-five dollars ($25.00) per year per member in annual dues, effective this year.

Action: A motion was made seconded and voted that the House supported this proposal and that it should be taken to the Council indicating the House's support.

Adjournment

There being no further business the meeting was adjourned at 4:55 PM.

Respectfully submitted:

Melvin D. Hoffman, MD
Secretary

Run for Your Life! — One of the oldest recorded governmental decrees concerning the practice of surgery was made by Hammurabi 2,000 years before the birth of Christ. He legislated specific remuneration for operations and specific penalties for failure. Thus if the patient died after an operation, the surgeon's hands were amputated. Later the Visigothic code also regulated surgeons' fees, and if the patient died the surgeon was to be turned over to the members of the deceased's family, who could then do with him as they willed. Some surgeons were executed after an unfavorable result. Pierre Franco, who in 1556, was the first to operate successfully for strangulated hernia, stated that ". . . if we have a mishap we must often run for our lives."

Contracts were often required not only between the surgeon and the patient but between the surgeon and the family as well. As many as 30 members of a family might sign the operative permit, the ultimate in informed consent. Furthermore, the concept of second opinion and peer review was well developed over 700 years ago. In the Annals of the Barber-Surgeons of London, *it is noted that a second opinion by a superior surgeon might be necessary before an operation was undertaken in 14th century England.*

. . . George L. Jordan, Jr. Presidential Address, Society for Surgery of the Alimentary Tract, American Journal of Surgery, *January 1980*

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Write to:

G. Rosenberg, MD
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Two sentence Essay — I'm a generalist myself now. I tried to read an article in the New England Journal of Medicine *the other night; I couldn't understand it.*

. . . Franz Ingelfinger, MD, Editor Emeritus of the New England Journal of Medicine

May 1980
Volume 63, Number 5

Rhode Island Medical Journal

L. MATHIEU, JR., MD
ENT 1980-1981
ISLAND MEDICAL SOCIETY
wsletter

CONTRIBUTIONS

Categorization of Hospitals in Rhode Island

Lennert's Lymphoma — Report of a Case with Unusual Presentation and Therapeutic Implications

Prednisone Therapy of Gold-induced Thrombocytopenia in a Rheumatoid Arthritis Patient

Authority, Freedom, and the Teenager

PRESIDENT'S PAGE

DEAN'S MESSAGE

EDITORIALS

LETTERS

RADIOGRAPHIC CASE OF THE MONTH

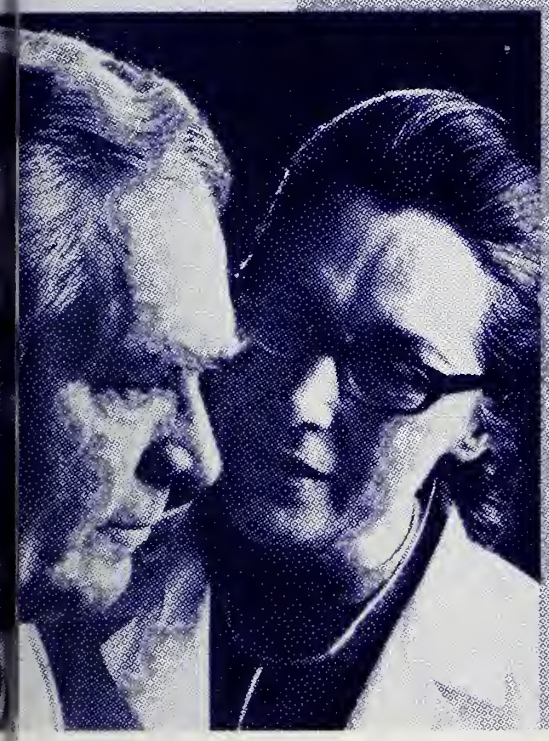
NEWSLETTER

Countway Lib of Medicine
10 Shattuck Street #510
Boston, MA 02115
Z-1

proven antianxiety

Highly specific calming action virtually free of unwanted side effects: this was the remarkable clinical promise of Librium (chlordiazepoxide HCl). And today this promise continues to be fulfilled in a wide variety of patients you see every day.

ROCHE



The published record on Librium is enormous. So large, in fact, it had to be put into a computer data bank and retrieval system. It's a record that shows Librium is highly effective in relieving anxiety; that Librium is seldom associated with serious side effects; that Librium rarely interferes with mental acuity at proper doses; that Librium is used concomitantly with primary medications. However, as with all CNS agents, patients should be warned against hazardous activities requiring complete alertness, and about possible combined effects with alcohol.

performance

Librium® ℞
chlordiazepoxide HCl/Roche

5mg, 10mg, 25mg capsules

synonymous with relief of anxiety

- An unsurpassed safety record
- Minimal effect on mental acuity, in proper dosage
- Predictable patient response
- Is used concomitantly with primary medications, such as anticholinergics and cardiovascular drugs

Please see next page for summary of product information.

Librium® 5mg, 10mg, 25mg capsules
chlordiazepoxide HCl/Roche

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of anxiety and tension occurring alone or accompanying various disease states. Efficacy beyond four months not established by systematic clinical studies. Periodic reassessment of therapy recommended.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Warn patients that mental and or physical abilities required for tasks such as driving or operating machinery may be impaired, as may be mental alertness in children, and that concomitant use with alcohol or CNS depressants may have an additive effect. Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage. Withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported.

Usage in Pregnancy: **Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema; minor menstrual irregularities; nausea and constipation; extrapyramidal symptoms; increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally; making periodic blood counts and liver function tests advisable during protracted therapy.

Usual Daily Dosage: Individualize for maximum beneficial effects. *Oral–Adults* Mild and moderate anxiety and tension, 5 or 10 mg *t.i.d.* or *q.i.d.*; severe states, 20 or 25 mg *t.i.d.* or *q.i.d.* *Geriatric patients* 5 mg *b.i.d.* to *q.i.d.* (See Precautions.)

Supplied: Librium® (chlordiazepoxide HCl) *Capsules*, 5 mg, 10 mg and 25 mg—bottles of 100 and 500; Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Paks of 50, available singly and in trays of 10. Libritabs® (chlordiazepoxide) *Tablets*, 5 mg, 10 mg and 25 mg—bottles of 100 and 500. With respect to clinical activity, capsules and tablets are indistinguishable.

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- provides effective symptomatic relief
- *b.i.d.* dosage simplifies therapy
- scored tablet for dosage flexibility

OPTIMINE®
azatadine maleate 1 mg tablets

CONTRAINDICATIONS Use in Newborn or Premature Infants. This drug should not be used in newborn or premature infants.

Use in Nursing Mothers. Because of the higher risk of antihistamines for infants generally and for newborns and prematures in particular, antihistamine therapy is contraindicated in nursing mothers.

Use in Lower Respiratory Disease. Antihistamines should NOT be used to treat lower respiratory tract symptoms including asthma.

Antihistamines are also contraindicated in the following conditions: hypersensitivity to azatadine maleate and other antihistamines of similar chemical structure; monoamine oxidase inhibitor therapy (See DRUG INTERACTIONS Section).

WARNINGS Antihistamines should be used with considerable caution in patients with: narrow angle glaucoma, stenosing peptic ulcer, pyloroduodenal obstruction, symptomatic prostatic hypertrophy, bladder neck obstruction.

Use in Children. In infants and children especially, antihistamines in overdosage may cause hallucinations, convulsions, or death.

As in adults, antihistamines may diminish mental alertness in children. In the young child, particularly, they may produce excitation.

OPTIMINE TABLETS ARE NOT INTENDED FOR USE IN CHILDREN UNDER 12 YEARS OF AGE.

Use in Pregnancy. Experience with this drug in pregnant women is inadequate to determine whether there exists a potential for harm to the developing fetus.

Use with CNS Depressants. Azatadine maleate has additive effects with alcohol and other CNS depressants (hypnotics, sedatives, tranquilizers, etc.).

Use in Activities Requiring Mental Alertness. Patients should be warned about engaging in activities requiring mental alertness, such as driving a car or operating appliances, machinery, etc.

Use in the Elderly (approximately 60 years or older). Antihistamines are more likely to cause dizziness, sedation and hypotension in elderly patients.

PRECAUTIONS Azatadine maleate has an atropine-like action and, therefore, should be used with caution in patients with: a history of bronchial asthma, increased intraocular pressure, hyperthyroidism, cardiovascular disease, hypertension.

DRUG INTERACTIONS MAO inhibitors prolong and intensify the anticholinergic (drying) effects of antihistamines.

ADVERSE REACTIONS The most frequent adverse reactions are underlined.

General Urticaria, drug rash, anaphylactic shock, photosensitivity, excessive perspiration, chills, dryness of mouth, nose and throat.

Cardiovascular System Hypotension, headache, palpitations, tachycardia, extrasystoles.

Hematologic System Hemolytic anemia, thrombocytopenia, agranulocytosis.

Nervous System Sedation, sleepiness, dizziness, disturbed coordination, fatigue, confusion, restlessness, excitation, nervousness, tremor, irritability, insomnia, euphoria, paresthesias, blurred vision, diplopia, vertigo, tinnitus, acute labyrinthitis, hysteria, neuritis, convulsions.

Gastrointestinal System Epigastric distress, anorexia, nausea, vomiting, diarrhea, constipation.

Genitourinary System Urinary frequency, difficult urination, urinary retention, early menses.

Respiratory System Thickening of bronchial secretions, tightness of chest and wheezing, nasal stuffiness.

OVERDOSAGE Antihistamine overdosage reactions may vary from central nervous system depression to stimulation. Stimulation is particularly likely in children. Atropine-like signs and symptoms (dry mouth, fixed, dilated pupils, flushing, and gastrointestinal symptoms) may also occur.

If vomiting has not occurred spontaneously, the patient should be induced to vomit. This is best done by having him drink a glass of water or milk after which he should be made to gag. Precautions against aspiration must be taken, especially in infants and children.

If vomiting is unsuccessful, gastric lavage is indicated within three hours after ingestion and even later if large amounts of milk or cream were given beforehand. Isotonic and ½ isotonic saline is the lavage solution of choice.

Saline cathartics, such as milk of magnesia, draw water into the bowel by osmosis and therefore are valuable for their action in rapid dilution of bowel content.

Stimulants should not be used.

Vasopressors may be used to treat hypotension.

FEBRUARY 1977 11055010

For more complete details, consult package insert or Schering literature available from your Schering Representative or Professional Services Department, Schering Corporation, Kenilworth, New Jersey 07033.

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SWW-417 I

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FIRST
for relief of allergy symptoms

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Please see adjacent brief summary of prescribing information.

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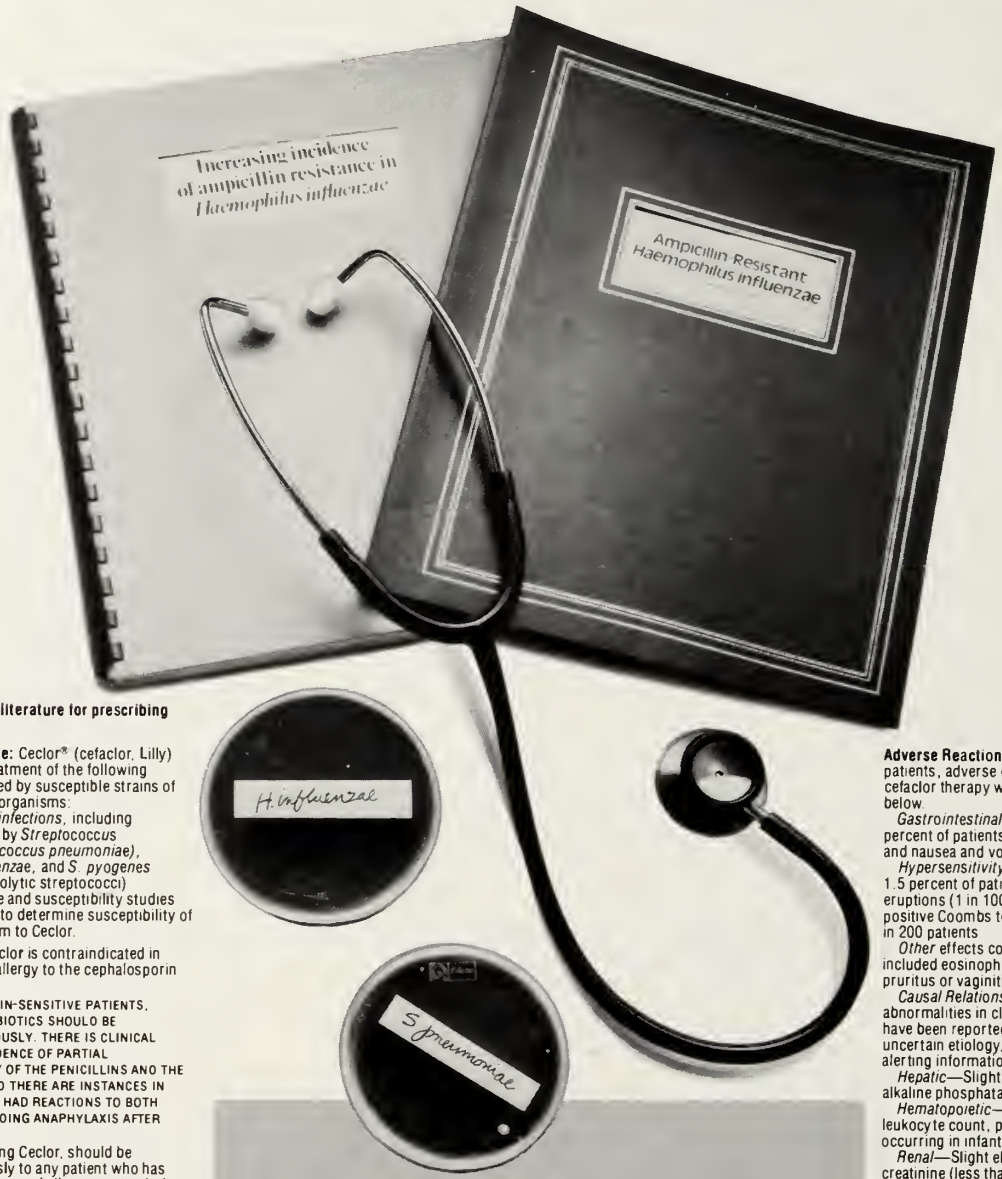
An added complication... in the treatment of bacterial bronchitis*


Increasing incidence of ampicillin resistance in Haemophilus influenzae
Ampicillin Resistant Haemophilus influenzae
H. influenzae
S. pneumoniae

Some ampicillin-resistant strains of Haemophilus influenzae—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Ceclor.[1-6]

In clinical trials, patients with bacterial bronchitis due to susceptible strains of Streptococcus pneumoniae, H. influenzae, S. pyogenes (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Ceclor.[7]

Ceclor®
cefaclor
Pulvules®, 250 and 500 mg

Brief Summary.
Consult the package literature for prescribing information.

Indications and Usage: Ceclor® (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae (Diplococcus pneumoniae)*, *Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci)

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor.

Contraindication: Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS TO BOTH DRUG CLASSES (INCLUDING ANAPHYLAXIS AFTER PARENTERAL USE).

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Precautions: If an allergic reaction to cefaclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of cefaclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs test may be due to the drug.

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such a condition, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

Usage in Pregnancy—Although no teratogenic or antifertility effects were seen in reproduction studies in mice and rats receiving up to 12 times the maximum human dose or in ferrets given three times the maximum human dose, the safety of this drug for use in human pregnancy has not been established. The benefits of the drug in pregnant women should be weighed against a possible risk to the fetus.

Usage in Infancy—Safety of this product for use in infants less than one month of age has not been established.

Adverse Reactions: In clinical studies in 1493 patients, adverse effects considered related to cefaclor therapy were uncommon and are listed below.

Gastrointestinal symptoms occurred in about 2 percent of patients and included diarrhea (1 in 70) and nausea and vomiting (1 in 90).

Hypersensitivity reactions were reported in abo 1.5 percent of patients and included morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs tests each occurred in less than in 200 patients.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genita pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain—Transitory abnormalities in clinical laboratory tests results have been reported. Although they were of uncertain etiology, they are listed below to serve a alerting information for the physician.

Hepatic—Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40)

Hematopoietic—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200). [070379

*Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.[8]

Note: Ceclor® (cefaclor) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allerg patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumat fever. See prescribing information.

References

1. Antimicrob. Agents Chemother., *8*:91, 1975.
2. Antimicrob. Agents Chemother., *11*:470, 1977.
3. Antimicrob. Agents Chemother., *13*:584, 1978.
4. Antimicrob. Agents Chemother., *12*:490, 1977.
5. Current Chemotherapy (edited by W. Siegenthaler and R. Luthy), II: 880. Washington, D.C.: American Society for Microbiology, 1978.
6. Antimicrob. Agents Chemother., *13*:861, 1978.
7. Data on file, Eli Lilly and Company.
8. Principles and Practice of Infectious Diseases (edited by G.L. Mandell, R.G. Douglas, Jr., and J.E. Bennett), p. 487. New York: John Wiley & Sons, 1979.

Additional information available the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285.

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May 1980
Volume 63, Number 5

Rhode Island Medical Journal

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Rhode Island Medical Journal is owned and published monthly by the Rhode Island Medical Society, 106 Francis Street, Providence, Rhode Island 02903, Ph: 401-331-3207
Copies $1.00-Subscriptions $10.00 per year (Members of the Rhode Island Medical Society, $5.00 annually), Second Class postage at Providence, Rhode Island
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NEWSLETTER

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dle Island Medical Society

May 1980

lewsletter

James R. Clarkin, Editor

w Past Presidents Advisory Council to the President of RIMS

h first meeting of the Past Presidents Advisory Cncil to the President of the Rhode Island Medical Sciety was held Thursday evening, April 17, in the Dvenport Room of the Rhode Island Medical Society Bding. In attendance were past presidents Drs. Fncis B. Sargeant (1958-1959); William A. Reid (1965-96); Stanley D. Davies (1967-1968); John J. Cunningai (1968-1969); Stanley D. Simon (1969-1970); Richard P. Sexton (1970-1971); Stephen J. Hoye (1975-1976); Hebert F. Hager (1976-1977); and Frank W. Sullivan (197-1978). Also present were John E. Farrell, former Excutive Director and Honorary Member of the Sciety; James R. Clarkin, Executive Director; Howard E. Lawton, Assistant Executive Director; Dr. Peter L. Mthieu, Jr., President-Elect; Dr. Betty B. Mathieu, ust; and Dr. Charles L. Hill, President.

ollowing reunion during cocktails and dinner each at president told of highlights of his year in office recalling events such as the Malpractice Crisis, eotiations over continuing medical education reuements for relicensure, establishment of the Board of Medical Review, years of staff transition, and also the tranquil times — each period with its lesson.

Thus duly founded, this new Advisory Council, which will be comprised of all active member past presidents of the Society, and which will be chaired by Dr. Charles L. Hill, President, will meet at least twice yearly to share experiences, provide continuity with the past, and present recommendations to the Society.

In closing comments at the meeting Dr. Peter L. Mathieu, Jr., President-Elect, announced his intention to present to the Rhode Island Medical Society Council at its June meeting two resolutions which will further involve past presidents in the Society's activities. First, it will be proposed that all past presidents will become honorary members of the Rhode Island Medical Society Council, to remain such as long as they remain members of the Society. Second, all past presidents having served their terms will become voting members of the House of Delegates for as long as they remain members of the Society.

ti-Conflict Calendar:

h Rhode Island Medical Society maintains an oning calendar of medical meetings and affairs. Call swhen you're scheduling — 331-3207 or 331-3208.

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Medical Meetings

MAY 1980

				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	31

2 SPARI Spring Meeting; Kent County Memorial Hospital; 8:00 pm

4 RIMS Annual Meeting; Cranston Hilton; (In conjunction will be meetings of RI District Branch, American Psychiatric Association; RI Society of Pathologists; RI Chapter, American College of Physicians; RI Chapter, American Academy of Pediatrics; RI Chapter, American College of Emergency Physicians; RI Society of Allergy; joint meeting of the Providence Surgical Society and American College of Surgeons; RI Society of Nuclear Medicine)

5 Pawtucket Medical Association; Annual Meeting

6 Miriam Hospital Women's Association Annual Meeting; Ledgemont Country Club; 11:30 am

7- Rhode Island Chapters, American College of Surgeons and American College of Physicians; joint meeting; Elbow Beach Hotel, Bermuda

2 Newport County Medical Society; dinner meeting and election of officers; Canfield House; 6:30 pm

4 Rhode Island Dermatological Society; regular meeting; The Memorial Hospital; 8:30 pm

Rhode Island Society of Internal Medicine; Annual Meeting; (May 28 tentative date)

Date to be decided

Current Legal and Financial Issues for the Practicing Physician

8 sessions — 5-6 pm — Mondays — Rhode Island Hospital — George Auditorium

May 5
Professional Financial Planning

- Advantages and disadvantages of corporate practice as opposed to sole proprietorship or partnership; various life, medical and disability benefits available; physican's "buy-in" to a practice; the ramifications of the death, disability or withdrawal of a partner or co-stockholder.
- For physician-employees, the essential nature of an employment contract and its contents, and tax aspects of various financing alternatives.

Panel: Professionals with current experience in the field from the law firm of Hinckley Allen Salisbury & Parsons.

May 12
May 19
The Doctor and the Judicial Process

- Types of legal proceedings in which physicians may become involved, with emphasis on medical malpractice litigation, workmen's compensation proceedings and appointment of guardians for patients.
- The substantive law of malpractice, and types of protective measures to minimize exposure.

Speaker: Thomas D. Gidley, Esq, who is presently engaged and has considerable experience representing physicians in medical malpractice proceedings.

June 2
Regulation of Physicians in the Practice of Medicine

- Constitutionality and necessity for state regulation for the public health, and for private or self-regulation.
- Examination, registration, recertification, reporting requirements, confidential information, medical records, patient rights, disciplinary matters, immunity, and certificate-of-need.

Speakers: John Hynes, Esq, former hospital administrator, presently in the practice of medical law. John J. Cunningham, MD, Delegate to the AMA from the Rhode Island Medical Society.

June 9
Private Practicing Physician's Relationship to Third-Party Payors

- Types of third-party payors and methods of establishing and updating the fee structures of private practitioners.
- Contractual relationships with Blue Shield, Medicare, Medicaid.
- Public Law 92-60 (PSROs) and Public Law 94-142 (Medicare fraud abuse amendments 1977).

Speaker: John Hynes Esq, former hospital administrator, and presently in the practice of medical law.

June 16
June 23
The Physician and the Hospital

- Medical staff membership.
- Contractual relationships between hospitals and physicians and groups of physicians.
- Legal and regulatory constraints which affect the physician/hospital relationship.

Speaker: Thomas R. Courage, Esq, who is presently engaged and has considerable experience in medical/lega practice.

June 30
Personal Financial Planning

- Estate planning, general tax planning, insurance needs, tax shelters, investment management.

Panel: Professionals with current experience in the field from the law firm of Hinckley Allen Salisbury & Parsons and the accounting firm of Harris & Gifford.

This activity meets the criteria for 8 credit hours in Category 1 of the Physician's Recognition Award of the American Medical Association, provided it is used and completed as designed. Sponsored by the Rhode Island Hospital, Department of Orthopaedic Surgery, in cooperation with the Brown University Program in Medicine and the Rhode Island Medical Society.

FIMS Officers: 1980-1981

The new officers to be installed at the 169th Annual Scientific Assembly on May 14, 1980 are Peter L. Mathieu, Jr., MD, President; Paul B. Metcalf, Jr., MD, Vice President; Charles E. Millard, MD, President-Elect; Melvin D. Hoffman, MD, Secretary; and Erminio R. Cardi, MD, Treasurer.

Dr. Peter L. Mathieu, Jr. brings to the office of *President* many years of active involvement in Rhode Island Medical Society activities. He has been Chairman of the Public Laws Committee for many years, as well as a member of the Publications Committee and Editorial Board of the *Rhode Island Medical Journal*. He has been a Delegate to the House from the Providence Medical Association, was Vice President and a member of the Council in 1977-1978, and President-Elect and Council member in 1979-1980. As President-Elect he has initiated and stimulated new committees, new projects, new directions, and new policies, which will be continued during his term of office and beyond it. Examples include his formation and chairmanship of a Membership Committee, with the goal not only of increasing membership, but also of increasing participation in Society affairs by those already members. He also was instrumental in forming the Past Presidents Advisory Council to the President of the Rhode Island Medical Society, which will meet regularly from now on to share perspectives and experiences of the past to cope with the problems and challenges of the future.

A graduate of Holy Cross College in 1946 and St. Louis University School of Medicine in 1948, Dr. Mathieu did postgraduate residency work at Rhode Island Hospital, Charles V. Chapin Hospital, Boston Children's Hospital, Beth Israel Hospital, House of God Samaritan and Providence Lying-In Hospital, before setting up in the private practice of pediatrics at 155 Waterman Street, Providence. He has practiced in his location for over 25 years, now with his wife and colleague Dr. Betty B. Mathieu, comprising Comprehensive Health Service Associates.

Dr. Mathieu's other affiliations include a Clinical Assistant Professorship of Pediatrics in the Brown University Program in Medicine, staff appointments at Rhode Island, Women & Infants, St. Joseph, Rhode Island and Medical Center and Roger Williams General Hospitals. He is presently the Director of Pediatrics at St. Joseph Hospital, Medical Director of Rhode Island School for the Deaf, and holds numerous memberships in professional societies including the American Medical Association, New England Allergy Society, New England Pediatric Society, American Academy of Pediatrics, American Academy of Allergy, American Association of Clinical Immunology and Allergy, American Association of Medical Writers, and the Irish American Pediatric Society. He has served on several Rhode Island state commissions, including the Governor's Child Advocate Commission, the Governor's Children's Code Commission, the Governor's Advisory Council for Child Welfare Services, the Governor's Advisory Council for Foster Children's Care, and the Governor's Advisory Council for Medicaid. He is presently or formerly on the Boards of Directors of the Sophia Little Home, Progress for Providence, Providence Health Centers, Providence Chamber of Commerce, Rhode Island Camps, Inc., Rhode Island Professional Standards Review Organization, and he is a past president and councillor of the Staff Physicians Association of Rhode Island.

New **Vice President** for 1980-1981 is **Dr. Paul B. Metcalf, Jr.**, founder and president of the Blackstone Valley Physicians Group (BVPG), Inc. Dr. Metcalf has supported Rhode Island Medical Society activities for many years. He is the Society representative to the SEARCH Board of Directors, chairman of the Society's Statistical Resources Committee, and has contributed extensively to recent efforts to represent the medical community in dialogue on the Rhode Island State Health System Plan, serving both the Voluntary Committee of Health Providers in their activities and on the Subcommittee on SHCC of the Committee on Delivery of Medical Care of the Rhode Island Medical Society.

Dr. Metcalf is an alumnus of Moses Brown School, Phillips Andover Academy, Yale University in 1941, and Harvard Medical School in 1943. He did postgraduate work in the Tumor Clinic of Massachusetts General Hospital, and at Springfield Hospital, Massachusetts Memorial Hospital, and Veterans Administration Hospital in Providence.

In the practice of general surgery in Pawtucket, he is past Chief of Surgery and presently Chief of Staff at Notre Dame Hospital, and on the staff at The Memorial Hospital. He is also chairman of the Data Analysis Committee and on the Board of Directors of Rhode Island Professional Standards Review Organization, and a past president of the Pawtucket Medical Association.

Dr. Charles E. Millard, Rhode Island Medical Society **President-Elect** for 1980-1981, is a family practitioner, and professionally active in the medical community. In the Society he is chairman of the Subcommittee on SHCC of the Committee on the Delivery of Medical Care, of which he is also chairman, and he has been the winner of the Rhode Island Medical Society Caleb Fiske Fund Essay Competition for the past three consecutive contests.

Dr. Millard was board certified as a specialist in Family Practice by the American Board of Family Practice in 1972, and recertified in 1978, one of only three doctors in the state to have been recertified. He is a charter Fellow of the American Academy of Family Physicians and has received numerous honors from that Academy. He was appointed to its Commission on Education, representing Region I, which includes New England, New York, Pennsylvania, Maryland, New Jersey, Delaware, and Washington, DC. More recently he was appointed by the Academy to participate in the preparation of a position paper on aging to be sub-

mitted to a national advisory group to the President of the United States. In 1948 Dr. Millard founded the Rhode Island Chapter of the American Academy of Family Practice and became its first president. Presently he is a member of the Board of Directors and chairman of the Chapter's Education Committee. For the past nine years he has been the delegate from Rhode Island to the National Convention of the American Academy of Family Physicians.

A graduate of George Washington University and Georgetown University School of Medicine in 1942, Dr. Millard has faculty affiliations with the Department of Community Medicine, Dartmouth Medical School; the Core Content Review program, Connecticut and Ohio Academies of General Practice; and MEDCOM in New York City; and he has published over 30 papers in various medical journals.

In 1977 Dr. Millard was named Outstanding Family Physician in the state by the Rhode Island Chapter of the American Academy of Family Physicians, the first and only time that this award has been made. He was also presented with the Chapter's Distinguished Public Service Award for his contributions in his state and his community.

Dr. Melvin D. Hoffman, serving as **Secretary** for 1980-1981, is a Providence internist. Dr. Hoffman graduated from Providence College, Hahnemann Medical College in Philadelphia, and served an internship at Rhode Island Hospital. Among his positions, he is Clinical Assistant Professor in the Brown University Program in Medicine, Chief of the Division of General Medicine at The Miriam Hospital, staff member of Rhode Island Hospital, courtesy staff member at Butler Hospital and Women and Infants Hospital, and a consulting physician at The Woonsocket Hospital. His professional affiliations include the American Medical Association, the American College of Physicians, the New England Diabetes Association, the New England Thoracic Association, the American and Rhode Island Heart Associations, the American Society of Internal Medicine, the Narragansett Council of the Boy Scouts of America, and the Rhode Island Interagency Council on Smoking; and he has actively served the Rhode Island Medical Society for years as Secretary and as chairman of its Mediation Committee.

Dr. Erminio R. Cardi, Rhode Island Medical Society **Treasurer** for 1980-1981, is in the private practice of general surgery in Cranston, Rhode Island. He is a graduate of Providence College in 1948, Georgetown University School of Medicine in 1952, and completed his internship at St. Joseph Hospital in Providence in 1953. He is on the staff and active in the affairs of St. Joseph Hospital, and he is a past president of the hospital's medical staff. He has served the Providence Medical Association as a member of its Executive Committee and for years as a Delegate to the House of the Rhode Island Medical Society.

SPARI Update

The Executive Committee of the Staff Physicia Association of Rhode Island (SPARI) held a dinn meeting on Monday, April 14, 1980 at 6:30 pm at t University Club, Providence. Present were Drs. Dav R. Hallmann, President; John C. Baxter, Vi President; Erminio Cardi, Secretary-Treasurer; Peter Mathieu, Jr.; Richard F. Judkins; Joan Abar; P. Jose Pesare; William F. Garrahan; and Mrs. Donald Larkin, Executive Secretary of the Association.

The Committee discussed pros, cons, and effects the recent designation by the Rhode Island Sta Department of Health of Rhode Island Hospital as regional trauma center and as a regional pois center.

See this issue:
"Categorization of Hospitals in Rhode Island"
(pp 151-155)

Other business of the Committee included (1) repo of negotiations with the Blues on schedules and facilitating record and information exchange betwe all parties; (2) report and acknowledgement of acco plishments of the Voluntary Committee of Heal Providers (VCOHP), which will continue to wo actively with its constituent organizations for sou and effective health planning. The Committee una mously endorsed the VCOHPs efforts, and will advi continued support and participation in its activities.

SPARI originated in 1974, organized by the Pro idence Medical Association and the five gene hospitals in Providence. It was then known as t Association of Presidents of Hospital Staffs. T recent name change was adopted to reflect the actu constituency of the organization — *all* hospital st physicians — represented by hospital staff president vice presidents, and immediate past presidents. SPA is supportive of the Rhode Island Medical Society, n competitive with it; a close working relationship exis between the two organizations. The aim of SPARI is promote sharing of ideas between hospital st physicians and mutual help in the solving of problem

Following is a list of SPARI representatives:

Bradley Hospital: Raymond W. Waggoner, MD; Hu Taussig, MD.

Butler Hospital: William Braden III, MD; Eliot Barr MD.

Cranston General Hospital: Robert W. Brochu, D William R. Lowney, DO; Joan Abar, DO.

Fogarty Memorial Hospital: Naeem M. Siddiqui, M Jean A. Marcellot, MD; Catello T. Scarano, MD.

Kent County Memorial Hospital: Lorand R. Brow MD; Oswaldo R. Velis, MD; William F. Garrahan, MD.

Memorial Hospital: David R. Hallmann, MD; Robe D. Tarro, MD; Richard Bertini, MD.

Miriam Hospital: Henry F. Izeman, MD; Philip Torgan, MD; Henry M. Litchman, MD.

Newport Hospital: Charles A. Hall, Jr., MD; Lew Arnow, MD; George T. Van Petten, MD.

Notre Dame Hospital: Paul B. Metcalf, Jr., M Jaroslaw Koropey, MD; George D. Noble, MD.

hode Island Hospital: Edward A. Iannuccilli, MD; Er ld H. Dahlquist, Jr., MD; Robert S. L. Kinder, MD.
oger Williams General Hospital: William M. Claiace, MD; Mario Tami, MD; P. Joseph Pesare, MD.
t. Joseph Hospital: Richard L. Testa, MD; John J. Coghlin, MD; Henry J. Robidoux, MD.
outh County Hospital: Agu Suvari, MD; Thomas A. Nictor, MD; Eugene B. McKee, MD.
Vesterly Hospital: Jesse M. Gibson, Jr., MD; Anthony J. Fusco, MD; Francis M. Palaia, MD.
Vomen & Infants Hospital: Herbert Ebner, MD; Clifton B. Potter, MD; Edward Cardillo, MD.
Voonsocket Hospital: Faridoon Kahn, MD; F. Edward Yazback, MD; John C. Baxter, MD.

Communications to SPARI can be directed to Mrs. Donald F. Larkin, Executive Secretary, 54 Kirby Avenue, Warwick, RI 02889, telephone 737-4949.

Medicare Paperwork Biggest Turnoff

According to *Medical Economics,* a recent analysis of Medicare programs in New England indicates that doctors are rankled most by cumbersome and aggravating paperwork, *not* a low reimbursement rate.

The processing in Connecticut, for example, is such a headache that only 45% of doctors there accept Medicare assignment, even though the state pays 88% of charges, the highest reimbursement rate in New England.

On the other hand, Rhode Island pays only 78% of charges, the lowest in the region, but has attracted an 81% assignment rate, the highest in the nation, by implementing simplified billing procedures.

Note to Readers

The *Rhode Island Medical Society Newsletter* is a monthly insert publication of the *Rhode Island Medical Journal.* It's aim is to provide news of medical and health affairs in our community. Your contributions and comments are welcomed.

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Rhode Island Formulary Commission — Progress for Cost Containment

The Rhode Island Formulary Commission was created in 1976 by enactment of the General Assembly with the duty to "prepare a formulary of less expensive generic or chemical and brand names of drugs and pharmaceuticals considered by the commission as therapeutically equivalent and interchangeable with specific brand name drugs and pharmaceuticals" (42-181-3). The Rhode Island Medical Society did not then favor the passage of a generic substitution law in Rhode Island, representing the view that generic drug writing was not good medical care, since a physician writing a prescription selects a *particular* drug on the basis of his knowledge of a *particular* patient's illness and years of experience with many, many drugs, which although similar, are not exactly alike. The issue of bioequivalence was of considerable concern. It was feared that comparable rates of absorption of drug products into the bloodstream cannot be safely established.

Furthermore, at the outset the law did not even make provision for physician appointees to the Formulary Commission!

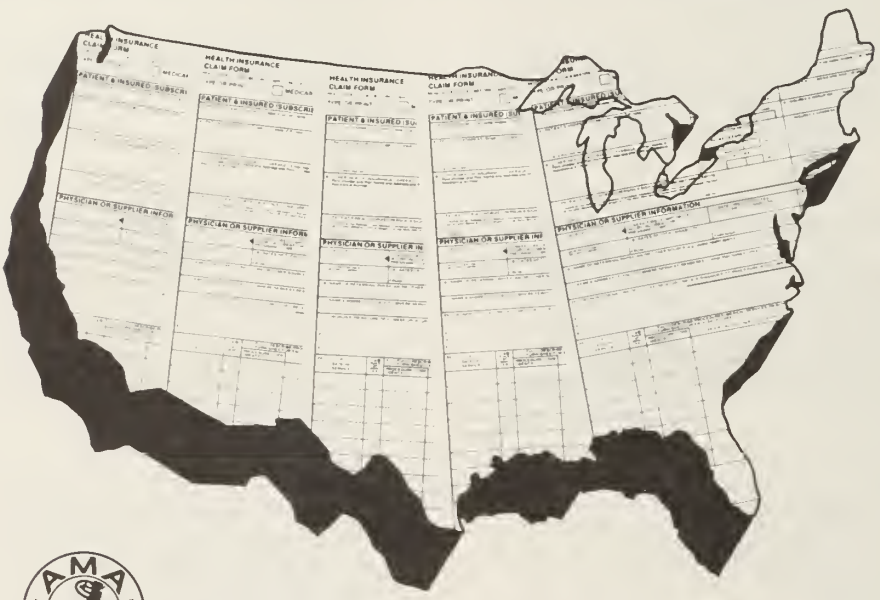
By the efforts of concerned physicians, by both personal and public editorial communications, the latter oversight was rectified. The Rhode Island Formulary Commission at its meeting of January 3, 1977 voted unanimously to support the appointment of physicians, which was duly accomplished. Dr. Edward Iannuccilli was appointed by the Governor to the Commission in September, 1978 for a three-year term to expire September, 1981. There also was established a position on the Commission for a physician to serve a one-year term from initial appointment, filled by an osteopathic physician.

The Commission's work began so slowly that even proponents of drug substitution were skeptical of its functions. It was rumored that the Pharmaceutical Manufacturers Association (PMA) contrived to support state commissions such as Rhode Island's to be obstructions to speedier measures such as adoption of already existent substitution lists. New York State's list of *Safe, Effective and Therapeutically Equivalent Prescription Drugs,* for example, included over 2,000 drug entities, when the Rhode Island Formulary Commission had still approved only 51.

Committed to accomplish its objectives, even in the midst of initial opposition, impatience, and criticism, the Commission is now geared to increased levels of productivity and confidence in its recommendations. A senior research technician and an executive secretary from the Rhode Island State Department of Health gather the data on drugs from all the relevant companies before presenting reports of findings to the Commission. The reports are comprehensive and in-depth. The quorum needed to conduct business by the 13-member Commission is 7 members, and there must be at least six affirmative votes for a drug to be admitted to the Rhode Island Formulary. In the last year the Commission has been acting on about 10 to 20 drugs per meeting.

In terms of both cost saving, which can be up to 80%, and convenience, the Rhode Island Formulary Commission is doing valuable work for Rhode Island, and it has earned the respect of the medical community.

This insurance claim form is the most widely used and accepted in America.



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PRESIDENT'S PAGE

On Communications Between Professionals

A very positive result of the Rhode Island State Health Plan presently evolving from deliberations of the Statewide Health Coordinating Council is the realization that misinformation and pure ignorance can be devastating to intelligent interaction and planning. This is evident in the emerging cry for increased recognition by "competing" health providers. Legal action in the past by the Rhode Island Optometric Association and presently by the Chiropractic Society of Rhode Island and the Rhode Island Podiatry Society bear witness to the need for improved communications between all professional bodies.

It is naive to persist in the obstructionist philosophy that the MD degree is the only training mechanism to provide that ethereal ability to perceive and remedy the multitude of genetic and environmental ills of mankind. As I become knowledgeable in other persuasions, I am impressed as to the advancement of training, the attempt at honest peer review, and the sincerity of most individuals to provide a fairly priced, quality service to their patients. We are at a truly critical period in our relationship. We may continue to object to sharing of facilities and patients and wait for the courts to create a system we shall all find detrimental, or we may study the qualifications and abilities

of each element of the system and create a sensible health provider network which recognizes the attributes of each provider and assures the community of reliable health care.

I am attempting to form a coordinating committee of health professionals to address common problems, as well as through this journal to provide the membership with as much information as possible for our own education in heretofore "heretical" agencies.

Charles L. Hill, MD

■

Important Notice on Medical Records:

The Rhode Island Medical Society executive office receives many calls from the public inquiring as to how medical records from a physician who may have retired, or left the area, may be located. Many times the requests are urgent, but unfortunately we often do not have the needed information.

All members, when they retire, or if they move, should let us know what person or institution is to be responsible for holding your records, and for how long. Just a quick phone call to us now could make a big difference to one of your patients someday in the future.

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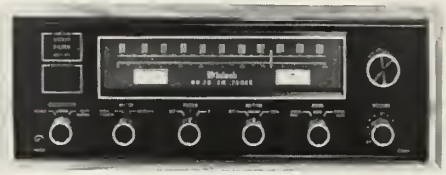

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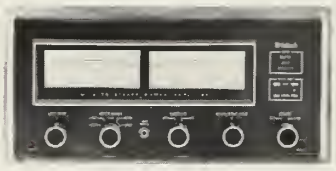

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DEAN'S MESSAGE

Internships Obtained by the Brown University Medical Students Class of 1980

Our sixth class of physicians will have completed their four years of medical education on June 2, 1980. These sixty-one men and women who will be awarded the MD degree at that time, have recently competed, along with about 16,000 other senior students in the United States medical schools, for the various internship positions throughout the United States.

The technical procedures for reconciling the preferences of the applying medical students (each of whom rank their internship choices) and the wishes of the hospitals (which also rank their applicants) are extremely complex and require a nationwide central agency. The National Resident Matching Program, based in Evanston, Illinois, is the managing mechanism for this intricate operation and is jointly supported and operated by such organizations as the American Medical Association, the Association of American Medical Colleges, the American Board of Medical Specialists and the American Hospital Association. The matching plan, in essence, preserves the free

Table 1: Internships Awarded to Brown MD Class of 1980

California (4)	
Pacific Medical Center (U of California)*	1
Stanford University Hospital	2
U of California Hospital, San Diego	1
Colorado (1)	
Mercy Hospital (U of Colorado)	1
Connecticut (4)	
Danbury Hospital	1
Yale-New Haven Medical Center	3
District of Columbia (3)	
Howard University Hospital	1
Walter Reed Army Medical Center (Uniform Services University)**	2
Florida (1)	
William Shands Hospital (U of Florida)	1
Illinois (1)	
McGaw Medical Center (Northwestern)	1
Massachusetts (6)	
Boston City Hospital (Boston U)	1
Boston University Hospital	1
Faulkner Hospital (Tufts U)	2
Newton-Wellesley Hospital (Tufts U)	1
Peter Bent Brigham Hospital (Harvard U)	1
New York (15)	
Beth Israel Hospital (Mt Sinai)	1
City Hospital (Mt Sinai)	1
Lenox Hill Hospital (New York Medical)	1
Long Island Jewish Hospital (State U of New York)	1
Montefiore Hospital Center (Einstein)	1
New York Hospital (Cornell)	1
New York U - Bellevue Medical Center	1
St Lukes Hospital Center (Columbia)	3
State U - Kings County Center	1
University of Rochester Hospitals	4
Ohio (3)	
Case-Western Reserve U Hospital	1
St Lukes Hospital (Case-Western)	1
Wright-Patterson Medical Center (Wright State)**	1
Pennsylvania (5)	
Children's Hospital of Pennsylvania (U of Penn)	1
Graduate Hospital (U of Penn)	2
Hahnemann Medical College Hospital	1
Lancaster General Hospital (Temple)	1
Rhode Island (13)	
Memorial Hospital (Brown)	1
Rhode Island Hospital (Brown)	9
Roger Williams General Hospital (Brown)	2
Women & Infants Hospital (Brown)	1
South Carolina (1)	
Richland Memorial Hospital (S Carolina)	1
South Dakota (1)	
University Hospital (U of S Dakota)	1
Texas (1)	
University Hospital, San Antonio (U of Texas)	1
Virginia (1)	
Fort Belvoir-DeWitt Army Hospital**	1

* unless obvious, the supervising medical school is indicated in parenthesis

** military facility

Table 2: Internships Obtained by Brown Graduates: Specialty Distribution Classes of 1975-80

Specialty	Graduating Class of: 1975	1976	1977	1978	1979	1980
Internal Medicine	27	33	24	33	31	27
Family Medicine	4	4	12	9	4	6
Pediatrics	11	7	3	11	8	9
Surgery	10	5	13	6	6	9
Psychiatry	1	1	3	1	2	2
Obstetrics & Gynecology	2	3	2	3	5	4
Pathology	0	1	2	0	1	2
Other	3	6	1	0	3	1
Total Graduates	58	60	60	63	60	60

Table 3: Internships Obtained by Brown Graduates: Regional Distribution Classes of 1975-80

Region	Graduating Class of: 1975	1976	1977	1978	1979	1980
Rhode Island	26	17	10	13	10	13
New England, other	7	12	8	7	8	10
Middle Atlantic States	14	9	25	23	22	23
South	0	3	3	7	7	3
Mid-West	6	8	7	9	5	5
Southwest	0	0	1	0	0	2
West	5	1	6	4	8	4
Total Graduates	58	60	60	63	60	60

choices of both hospital and student since it neither dictates candidate distribution, nor limits the number of candidates, nor requires a hospital to hire an unacceptable applicant, nor approves or disapproves of the individual hospital programs. It merely offers a neutral and totally equitable mechanism whereby the 18,055 first year graduate medical education positions (still nostalgically called internships by some) are matched with the approximately 16,000 contending candidates. Obviously, the desirability of each of these 18,000 jobs is not the same: some geographic locations are more sought-after than others; some institutions are more prestigious than others; some specialties are over-subscribed (eg, internal medicine) while positions in others tend to go unfilled (eg, anesthesiology, physical medicine, pathology, psychiatry).

All of the sixty senior medical students at Brown University were matched this year. (Nationally, about 8 per cent of the 1980 applicants went unmatched).

The hospital assignments for the sixty Brown University medical students graduating this year are listed in Table 1. Four of our 60 students, in fulfillment of military obligations, will be taking their graduate medical education training at Army or Air Force installations.

All of the 60 internships listed in Table 1 are of the categorical variety (ie, confined to one specialty.) Beginning in July of 1980, these graduates will be training in 14 states as well as the District of Columbia, in 40 different hospitals or medical centers and under the academic jurisdiction of 29 different colleges of medicine.

Close to 25 percent of our graduating students continue to take their training in the teaching hospitals affiliated with Brown University. Of the 361 Brown graduates holding the MD degree, (as of June of this year), 89 have elected local internships.

In terms of specialty distribution (Table 2) the frequency pattern is essentially similar to the professional choices pursued by the preceding medical classes of 1975-79. The majority of Brown graduates continue to enter post-graduate training programs in primary care medicine (defined as internal medicine, family medicine and pediatrics). Internal medicine continues to attract about half of the graduating class (somewhat above national averages) while the percentage of Brown graduates entering surgery is somewhat lower than the national mean.

Prior graduating classes have also been accepted to a wide variety of hospitals, impressive in terms both of their geographic diversity (Table 3) and academic stature; and our graduates have performed well in these highly competitive institutions. We have every reason to believe that the sixth group of physicians to be graduated from Brown University will similarly prosper.

Stanley M. Aronson, MD
Dean of Medicine
Brown University ■

EDITORIALS

Regional Trauma Center

Published elsewhere in this issue of the *Journal* (pages 151-155) is a paper urging the establishment of a regional trauma center in Rhode Island and categorization of all hospitals in the state according to their capabilities in the management of acute trauma cases.

It is now well established that the mortality in major trauma and other critical emergencies is appreciably affected not only by the speed with which the critically injured or ill are brought to treatment units but also by the capabilities of the receiving hospitals.

In each case a determination has to be made as to whether 1) to stabilize the patient, admit, and provide definitive care, 2) to stabilize only and transfer the patient, or 3) to transfer the patient directly to another hospital.

There is no doubt that most acute general hospitals in the state are qualified to handle moderately severe injuries effectively, and in fact have been doing so with increasing effectiveness over the years. The decision in each case, therefore, has to be in which of the above categories a given patient belongs. Doctor Porter has suggested ways in which this can be done. At the present time transferral is generally to the Rhode Island Hospital. It is thus already acting in an ad hoc manner as a regional trauma center.

Doctor Porter is in effect proposing that this informal arrangement be formalized — that Rhode Island Hospital be established as the official Regional Trauma Center for the Rhode Island metropolitan area in accordance with guidelines established under the federal Emergency Medical Services Systems Act, the AMA Commission on Emergency Medical Services, the American College of Surgeons, and the Joint Commission on Accreditation of Hospitals.

Most of the essential facilities and services are in place at Rhode Island Hospital. Other necessary requirements, including space considerations, can be provided if the commitment is made. Such designation will make available additional financial support. This can be accomplished if the necessary good will and desire for cooperation are engendered among the agencies involved, including the individual hospitals, the hospital association, the federal government, the State Health Department, and the state Health Planning Council.

It is a desirable goal and will save lives. We urge prompt action in this cooperative enterprise.

Work History Following Coronary Bypass

While a small cloud of controversy still hangs over the operation of coronary bypass, predicated upon the large impact on the cost of medical care of the thousands of these expensive operations performed, a consensus appears to be forming that the operation has an acceptable mortality and morbidity and is on the whole worthwhile economically, symptomatically, and functionally.

The Metropolitan Life Insurance Company, that massive generator of health statistics, with a large stake in the costs involved, has taken a perceptive look at the problem. It has examined not only the literature on the subject, but also the experience of its own employees.[1]

Currently 70,000 such operations are performed annually at a cost ranging from $10,000 to $15,000 per case. A report by

Rimm and coworkers[2] indicates that of 817 men actively employed prior to surgery 83 per cent returned to employment following surgery, while 17 per cent retired. In a study by Barnes, et al[3] 66 per cent returned to full-time work, 13 per cent reduced their hours, while 21 per cent stopped working. In a third study of Barnes et al, 79 per cent of those able to work prior to surgery returned to work.

In the metropolitan study the majority of the employees were office or sales personnel, and all had been actively at work or on temporary disability. Those who did not return to work in one year were considered as not having recovered from the operation. Employees in the study had financial incentives to return to work promptly, since failure to resume work when able resulted in termination of disability benefits.

Seventy-one (71) (68 male, 3 female) underwent the bypass operation during the three years 1974 through 1976. Ages ranged from 31 to 64, with an average of 52.

Forty-one patients (58 per cent) recovered and returned to work. Two patients died, one in the hospital and one shortly thereafter. The remaining 28 employees (39 per cent) were unable to resume work within one year and are considered as unlikely to return to employment. A somewhat larger percentage of the younger patients (under 55) returned to work than the older (over 55). Nine-tenths of office personnel returned to work as compared to slightly more than half of sales personnel, indicating the influence of type of job and life-style.

Also significant, however, is the fact that of the 41 who returned to work, 17 had varying degrees of recurrent disability during the follow-up period. Five became permanently disabled during the follow-up period, while five were on temporary disability at the end of the period. One employee underwent a second bypass. The rate of recurrent disability among sales personnel was about double that of office personnel.

These studies appear to indicate that based on ability to return to work coronary bypass surgery is worthwhile. It is, however, not an unmixed blessing. While the operation probably is here to stay, all of the evidence is still not in.

References

[1]Work history following coronary bypass surgery. *Metropolitan Life Insurance Company Statistical Bulletin* 60:3-4, Oct-Dec 79.

[2]Rimm AA, et al: Changes in occupation after aortocoronary vein bypass. *JAMA* 236:361-364, 1976. Cited in 1 above.

[3]Barnes GK, et al: Changes in working status of patients following coronary bypass surgery. *JAMA* 238:1259-1262, 1977. Cited in 1 above.

[4]Symmes JC, et al: Influence of aortocoronary bypass surgery on employment. *Can Med Assoc J* 118:268-270, 1978. Cited in 1 above.

On Our Youth and Our Society

This issue of the *Rhode Island Medical Journal* features a paper by Reverend Joseph L. Lennon, OP, titled "Authority, Freedom, and the Teenager". It was a pleasure to review this paper prior to its publication. The paper refers to the concept that school personnel stand *in loco parentis,* and advocates that substitute parenthood continue to be held as a philosophy in our schools. I strongly support Reverend Lennon's position on this subject.

At one time the doctrine *in loco parentis* was accepted by all. In recent years it has fallen into disrepute, and institutions of higher learning, in particular, have abdicated authority over their students, both in and out of the classroom. Indeed, many colleges do not even require attendance at classes, and in many institutions academic requirements for degrees are reduced from those which existed in years past. There has been a loss of positive parameters by which students can gain social orientation and some security from the confusions which accompany normal growth and development.

Educational institutions should thoughtfully work out ways to provide the proper balance between freedom and authority, and liberty and responsibility. They should strive to create functional guidelines for children and youth, to help them to grow up and to take places of responsibility in the world. Unfortunately a kind of "laissez-faire" attitude toward the problems of youth in the schools is widespread. It is time to think very hard about what we are doing to our children, and to rectify our mistakes, so that when our children do become

society's adults, they might better survive.

It is an often said truth that freedom without authority leads to the dissolution of both authority and freedom.

As a pediatrician I observe children growing from infancy through the ages of pre-school and the early grades to become teenagers. Through the ages of turbulence from about twelve to twenty-one years of age, youth are constantly seeking freedom from the constraints of childhood. Schools should become co-partners with parents to make sure that these youths do not have more freedom than their years can handle. The schools are professionals and the parents are loving. It is a good combination.

Recently we have read in the papers that a Swedish government committee on children's rights has recommended that children in Sweden be permitted to divorce their parents. In conversation with a Swedish director of pediatrics visiting Rhode Island Hospital recently, I learned that the child divorce law in Sweden is really a child advocate law. In a society in which decisions have often been made for adults rather than for children, this law was designed for the children who have no parents, who have been abandoned and who are seeking to establish some form of legitimacy. Another law recently passed in Sweden is the spanking law. While it carries no penalties and government officials concede it is virtually unenforceable, yet it reflects an attitude which prefers responsible authority to tyrannical measures when freedom becomes out of control.

Peter L. Mathieu, Jr., MD

LETTER

Physician Owned Insurance Company

To the Editor:

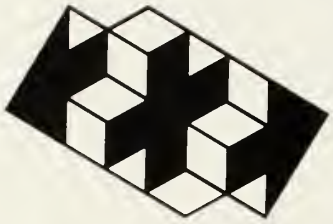
I have read the letter by Doctor H. Gerald Rock in the Rhode Island Medical Journal, Volume 63, Number 3 (March 1980), regarding a physician owned medical malpractice insurance company. The letter expresses anxieties and reservations on a subject that I feel deserves a fuller explanation.

There is a basic error in believing that an insolvency situation for a physician owned insurance company would cause physicians to "become personally responsible for claims brought in the future by their patients". A physician owned company would have by law exactly the same protection as is enjoyed by the Joint Underwriting Association (JUA). In effect, if the JUA *or* a physician owned company were to become bankrupt, then all insurance companies operating within Rhode Island would share responsibility for claims.

Doctor Rock's letter correctly observes that medical malpractice claims and awards recently have increased throughout the country. Because of this the JUA will probably again this year seek increased rates. It is for this reason that a charter for a physician owned company is a necessity, to provide us with a viable alternative to the JUA, if needed — the alternative to form a physician owned insurance company similar to those now in operation in 22 states insuring some 45 per cent of all physicians.

Over the years responsibility for the delivery of medical care slowly has been taken from physicians and gradually has been placed in the hands of committees, bureaucrats, retired news writers, and politicians. A physician owned company would be a token of our serious intent to regain leadership and responsibility in medical care delivery. We must move decisively, united in our purposes and commitments.

Frank M. D'Alessandro, MD



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RADIOGRAPHIC CASE OF THE MONTH

From The Miriam Hospital, Department of Diagnostic Radiology, Providence, Rhode Island

Background:

A frontal chest (upper left) and lateral chest (upper right) are shown on an asymptomatic 19-year-old female applying for employment. A tomogram (lower left) which was subsequently obtained is also presented.

Radiographic Findings:

A round, smooth, well-marginated mass is seen in the right perihilar area. No calcification is seen. No cavitation within the mass is identified. There is no evidence of other nodules or bronchial compression.

For diagnosis and discussion turn to next page.

Differential diagnosis:

1. Bronchial adenoma — This lesion is usually lobulated. Eighty percent are related to a bronchus and produce peripheral atelectasis or infiltrate. The most common presenting age is in the late thirties or early forties. Fifty percent present with hemoptysis.

2. Hamartoma — This lesion is usually in a peripheral location and lobulated. Twenty-five percent show a dense "popcorn" calcification. Peak incidence is in the sixth decade.

3. Tuberculoma — This mass is also usually lobulated. Most are seen in an upper lobe. Eighty percent have "satellite" lesions. Calcifications and bronchial involvement are frequent. The patient may be asymptomatic.

4. Bronchogenic carcinoma — This lesion usually has indiscrete irregular margins. They are usually symptomatic and bronchial involvement is frequent. Peak incidence is in the fifth and sixth decades.

5. Arterio-venous malformation — This lesion is usually lobulated. Large feeding arteries and draining veins usually can be identified on tomography. Angiography will confirm the diagnosis.

6. Bronchogenic cyst — This lesion has smooth-borders, and is not lobulated. Bronchi are not affected. Lower lobes are the most common pulmonary parenchymal location. The patient is usually asymptomatic and presents in the third decade of life. Internal calcification is not seen.

7. Other less common lesions that may present as a solitary mass include histoplasmoma, leiomyoma, fibroma, lipoma, amyloidoma, and inflammatory pseudotumors.

Diagnosis:
Bronchogenic cyst

Discussion:

Although any of the above lesions could conceivably present as demonstrated in this case, a combination of radiographic characteristics and history suggest a bronchogenic cyst as the most likely diagnosis.

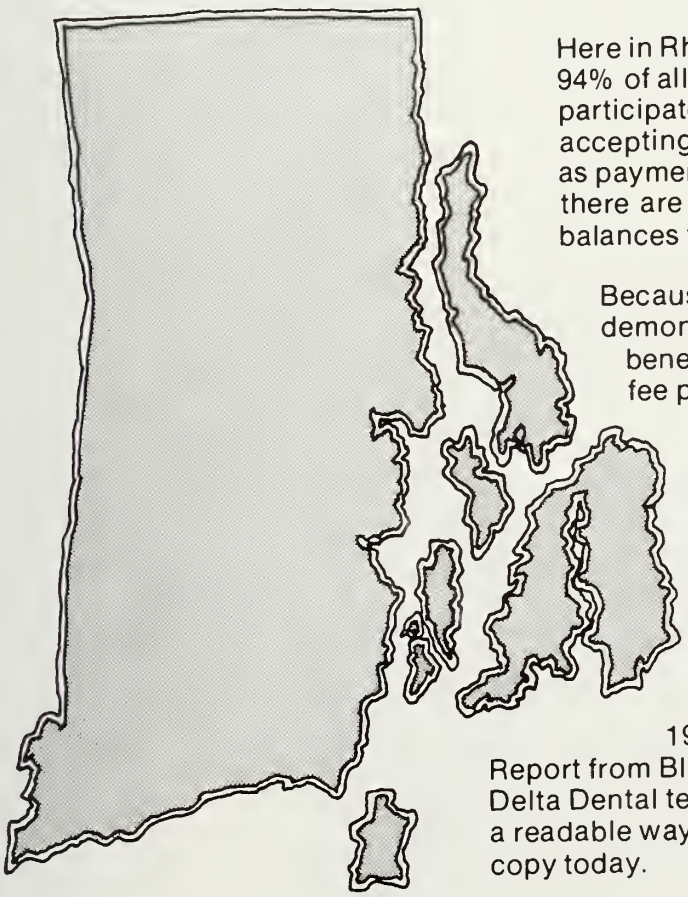
A bronchogenic cyst results from an abnormality in budding or branching of the tracheal or bronchial tree during its embryonic development. Cysts may develop in either the pulmonary parenchyma or in the mediastinum. They are most common in the third decade of life. The cysts are thin-walled, bound by respiratory epithelium, and filled with mucoid material. The walls rarely calcify. A typical parenchymal cyst presents as a sharply circumscribed, solitary, round or oval density with smooth borders. Ordinarily, they do not communicate with the tracheobronchial tree. If bronchial communication is established, an air-fluid level may be seen and the cysts may become infected. When uninfected, the cysts are asymptomatic and are usually discovered by serendipity on a routine chest roentgenograph. If the cyst is not removed surgically, approximately 75 per cent will eventually become infected and hemoptysis, bronchiectasis, or pneumonia may result.

References

Fraser RG, Pare JA: Diagnosis of Diseases of the Chest. Philadelphia, WB Saunders Co, 1970, pp 581-583.

Rogers LF, Osmer JC: Bronchogenic cyst: a review of 46 cases. Amer J Roentgen 91:273-283, 1964.

94% Is a Healthy Rate of Interest



Here in Rhode Island, more than 94% of all practicing physicians participate in Blue Shield by accepting Plan 100 allowances as payment-in- full, which means there are usually no unpaid balances for patients.

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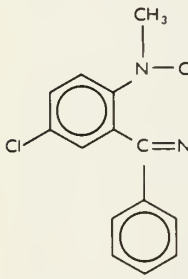
Aspects of Management

What to tell your patients when you prescribe Valium® (diazepam/Roche)

Survey shows significant correlation between comprehension and compliance



A study of compliance patterns reveals that more than 6 out of 10 patients made errors in self-administration of prescribed medication, largely due to lack of comprehension.* Misunderstanding of directions resulted in discrepancies in dosage schedules as well as in length of therapy. Since evidence suggests that expanded verbal instructions may encourage compliance, the patient receiving Valium can benefit from your explanation of the dosage regimen, what response to expect from therapy and when to expect it.

What Valium (diazepam/Roche) can do

Your patients should know that 1) you are prescribing Valium as an adjunct to an overall program for the treatment of anxiety, and 2) Valium is given to relieve the symptoms of excessive anxiety and psychic tension while you help the patient to explore and deal with the underlying cause of his psychic tension.

Patients often interpret manifestations of anxiety, such as palpitations, hyperventilation, fatigue and muscle tension, as symptoms of a serious disease. However, when they learn that these symptoms can be relieved by Valium therapy, patients can more readily understand the psychosomatic origin of their symptoms and to accept the nonpharmacologic measures you may recommend.

The time you devote to these explanations can be a therapeutic measure in itself. Most anxious patients respond to and benefit from a frank discussion with an objective, sympathetic professional.

At the start of treatment, establishing therapeutic goals helps the patient to learn *what* to expect and *when* to expect it. Patients should also be informed that the medication will be gradually reduced and discontinued upon attainment of the therapeutic goal.

Tapering of dosage is rarely necessary in short-term therapy, but when consistently higher doses are used for extended periods, patients should know that the gradual reduction of medication will be implemented in order to avoid sudden recurrence of symptoms or possible withdrawal symptoms. Such recurrence is unlikely when the causes of the anxiety have been worked out satisfactorily within your overall treatment program.

What Valium (diazepam/Roche) can't do

It should be emphasized that there is no "magic" in any antianxiety tablet; that medication is not prescribed as a problem solver. Instead, Valium is being prescribed *as a temporary measure to relieve symptoms* generated by excessive anxiety and psychic tension.

* Boyd JR, *et al*: *Am J Hosp Pharm 31*: 485-491, May 1974

Before prescribing, please consult complete product information, a summary of which follows:

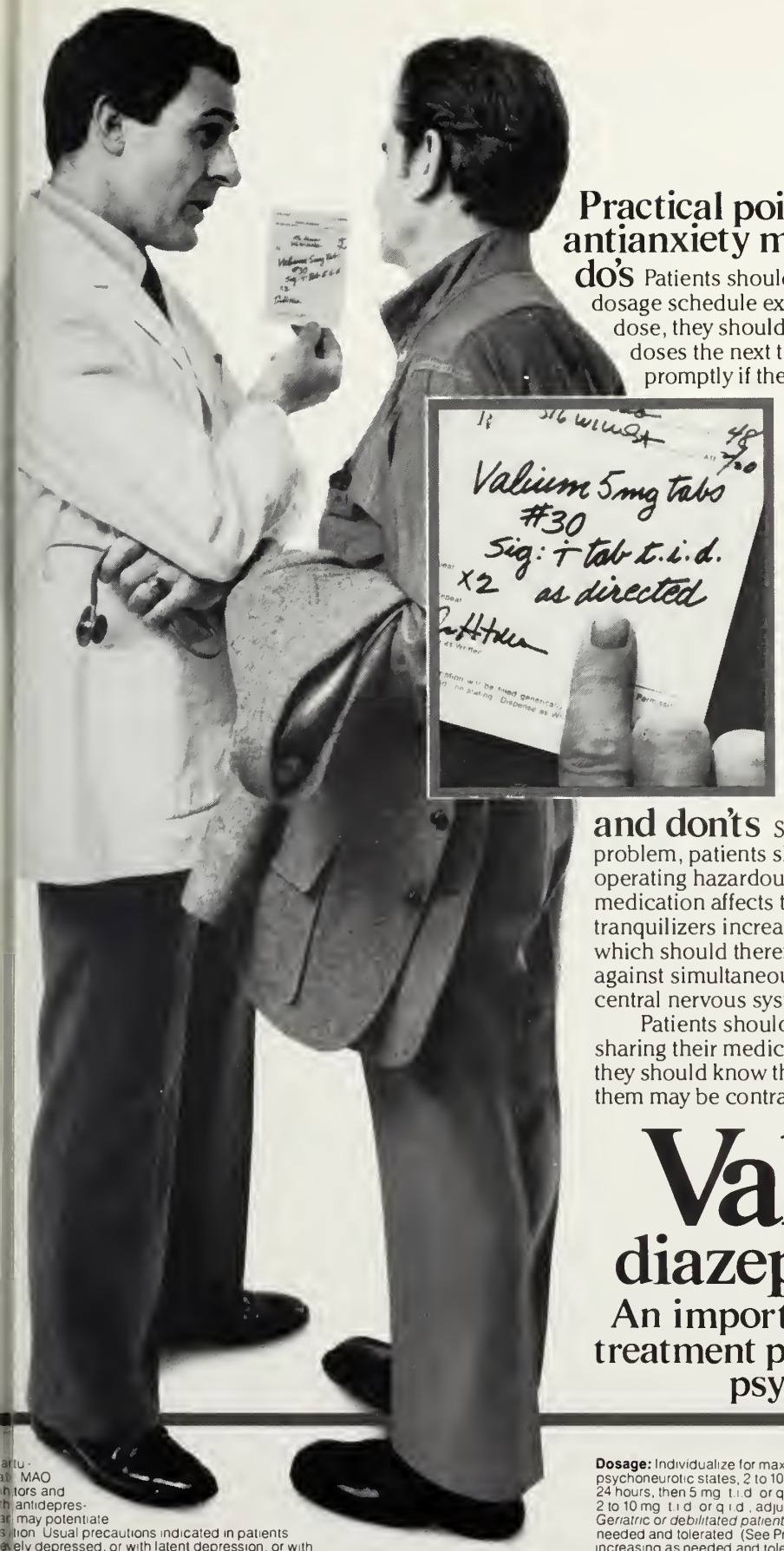
Indications: Tension and anxiety associated with anxiety disorders, transient situational disturbances and functional or organic disorders, psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms, or agitation, symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal, adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).
The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma, may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication, abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed, drugs such as phenothiazines, narcotics,



Practical pointers on taking antianxiety medications

do's Patients should be instructed to keep to their dosage schedule exactly as prescribed. If they miss a dose, they should not try to make it up by taking two doses the next time. Ask them to contact you promptly if they experience worrisome side effects. Explain that drowsiness is a common reaction to almost all calming agents, but that it usually subsides in a few days. Urge the patient to contact you for a possible dosage adjustment if drowsiness or other reactions persist.

Just as you request a complete list of all medications the patient is taking, suggest that this list be given to any other physician treating her/him.

Like all medicines, Valium should be kept out of reach of children and young people. Old or unused medication should be discarded.

and don'ts Since drowsiness is an occasional problem, patients should be advised against driving or operating hazardous machinery until they see how the medication affects them. They should also know that tranquilizers increase the effects of alcoholic beverages, which should therefore be avoided. Also, warn patients against simultaneous use of drugs that depress the central nervous system, particularly sedative hypnotics.

Patients should be aware of the importance of not sharing their medications with friends and neighbors; they should know that what you have prescribed for them may be contraindicated for others.

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dosage to smallest effective amount in elderly and debilitated to preclude ataxia or
edation

Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea,
e, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache,
tinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention,
ed vision. Paradoxical reactions such as acute hyperexcited states, anxiety,
cinations, increased muscle spasticity, insomnia, rage, sleep disturbances,
lation have been reported, should these occur, discontinue drug. Isolated reports
utropenia, jaundice, periodic blood counts and liver function tests advisable
g long-term therapy

Dosage: Individualize for maximum beneficial effect. *Adults:* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d., alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed, adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d., adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

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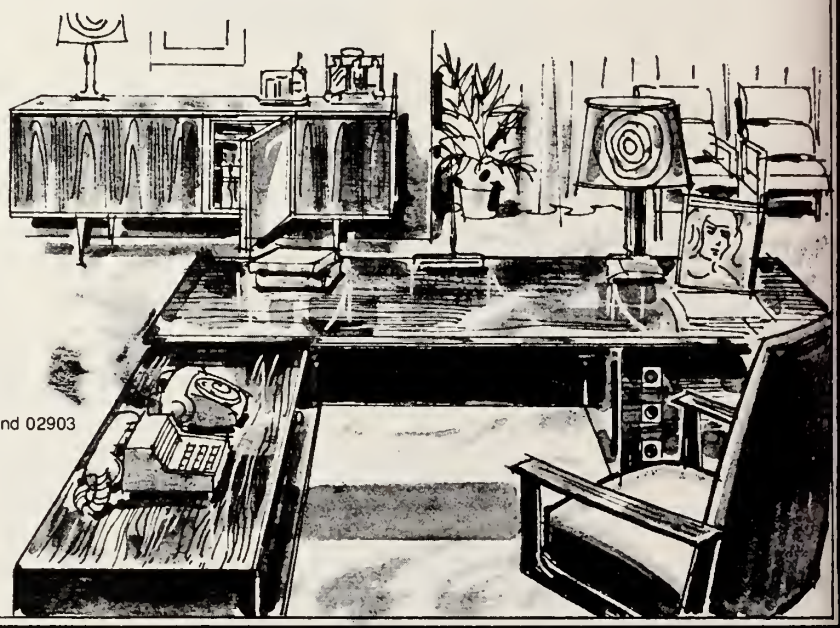

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Final classification of the less-than-effective indications requires further investigation.

Contraindications: Glaucoma, prostatic hypertrophy, benign bladder neck obstruction; hypersensitivity to chlordiazepoxide HCl and/or clinium Bromide

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium® (chlordiazepoxide HCl/Roche) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) reported following discontinuation of the drug.

Usage in Pregnancy: **Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.**

As with all anticholinergics, inhibition of lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established.

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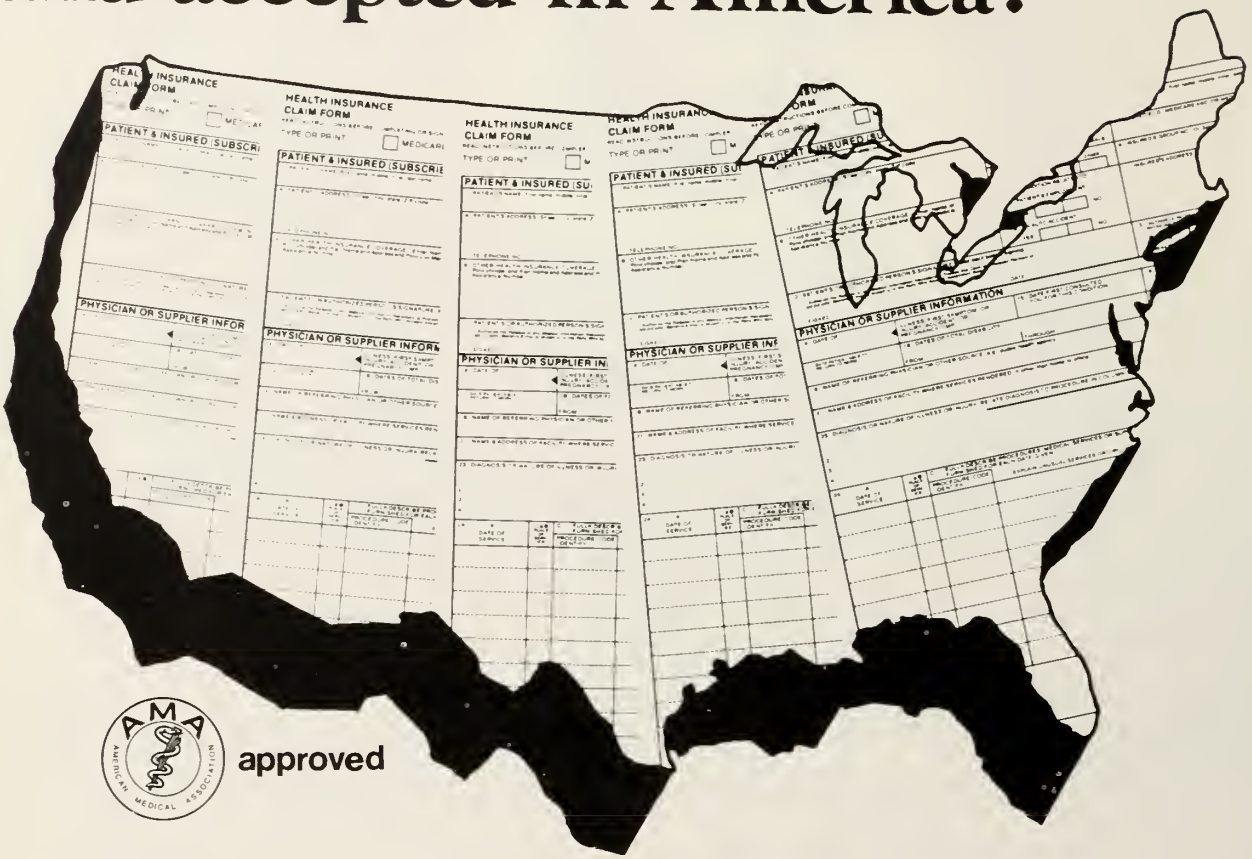

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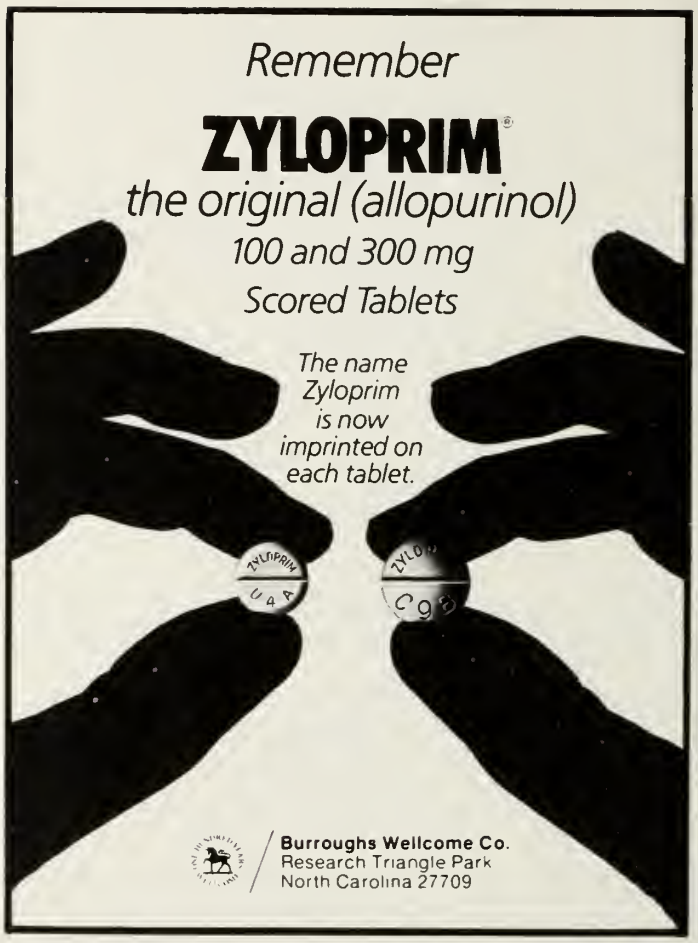

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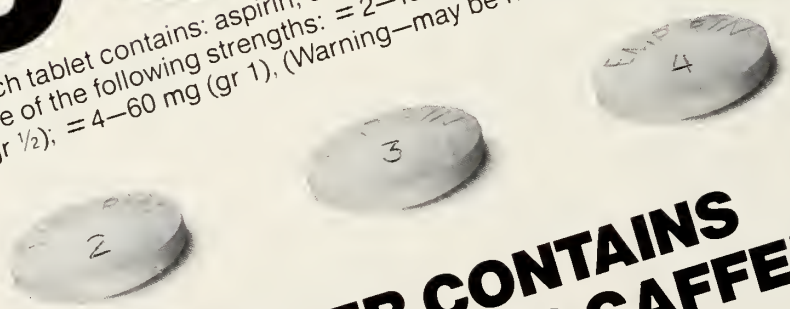

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Categorization of Hospitals in Rhode Island

Only Rhode Island Hospital Can Fulfill the Requirements for a Regional Trauma Center in Rhode Island

Arnold Porter, MD

Historical Background

In September 1966 the Committee on Trauma and the Committee on Shock of the Division of Medical Sciences, National Academy of Sciences National Research Council published a White Paper titled "Accidental Death and Disability: The Neglected Disease of Modern Society". It was the result of a three year study by representatives of a large number of organizations into the status of the initial care and emergency medical services afforded to victims of accidental injury. The report summarized the deliberations, and was designed to reduce accidental death and disability. To accomplish this goal many significant recommendations were made, one of which was accreditation and categorization of hospital emergency departments. The dictum then current that an ambulance should deliver a patient to the nearest emergency unit was considered to be no longer acceptable. The patient should be transported to the emergency department best prepared to care for his specific problem. In the absence of a descriptive categorization of the level of care that might be expected at a facility, neither the public, nor the patient, nor an ambulance driver could judge which facility was adequate to the immediate need. The public and rescue vehicles must be thoroughly informed of the extent of care that can be administered at emergency departments and hospitals of varying levels of competence. An honest and realistic categorization of the capabilities of emergency departments and their hospital back-up intensive care facilities appeared to be the logical solution to this problem. It was suggested that there might be four levels of care categorized as follows: *Type 1.* The Advanced First Aid Facility, *Type 2.* The Limited Emergency Facility, *Type 3.* The Major Emergency Facility, and *Type 4.* The Emergency Facility Combined with a Trauma Research Unit. The last-named was designed to be the ultimate goal in combining the highest development in patient care with research facilities. The White Paper should be required reading for anyone interested or involved in the emergency aspects of medical care. Categorization is only one of the many topics discussed and recommendations made to improve emergency services.

The initial federal effort to require categorization of hospital emergency capabilities was specified in the Department of Transportation Highway Safety Act of 1966 (Standard 11).

Since this manuscript was submitted for publication, Rhode Island Hospital has been designated as a Regional Trauma Center for the state by the Rhode Island Department of Health.

Arnold Porter, MD, Director, Emergency Department, Rhode Island Hospital, Providence, Rhode Island.

In the Program Manual for this act, published in 1969, guidelines are listed for three levels of Emergency Medical Facility Categorization: Class I Facility (Major Emergency Department), Class II (Limited Emergency Department), and Class III (Provisional Emergency Unit). The Highway Safety Act was passed only after searching inquiry by the United States Senate and House of Representatives and after considerable public discussion of the many important issues involved. Emergency Medical Services for persons injured in highway accidents was one such issue, as many people in the United States died needlessly or were permanently disabled as a result of inadequately organized emergency services.

In 1971 the AMA Commission on Emergency Medical Services (EMS) sponsored a multidisciplinary conference on Categorization of Hospital Emergency Services. Representatives of medical associations and other organizations having an interest in the problem participated. Included were the American Medical Association, the American College of Surgeons, the American Society of Anesthesiologists, the American Academy of Pediatrics, the American Academy of Family Physicians, the American College of Physicians, the American Hospital Association, the Department of Transportation, the Department of Health, Education and Welfare, and the National Academy of Sciences.

The conference was convened because of the concern of many key medical organizations and knowledgeable physicians about the uneven quality of emergency medical care provided in hospitals. A system of categorization of hospital emergency service capabilities was identified by the conference as one means of improving significantly the medical care of the critically ill or seriously injured. The published report of that conference, "Recommendations of the Conference on the Guidelines for Categorization of Hospital Emergency Capabilities" (a 1971 AMA publication), served as a reference or set of guidelines based on consensus for use by all those persons considering implementation of categorization in their regions. The American Medical Association conference recommended four categories of Emergency Facilities: Comprehensive, Major, General, and Basic Services.

The next important historic event in the development of EMS was the "Emergency Medical Services Systems Act" of 1973, which placed a great deal of emphasis on categorization. It will be discussed in the following portion of this paper describing categorization development in Rhode Island.

Categorization in Rhode Island

In Rhode Island in the late 1960s there was activity in the field of Emergency Medical Services through the efforts of the Committee on Emergency Medical Services of the Rhode Island Medical Society and the Citizen's Advisory Committee of the State Department of Health. The Subject of categorization, however, was not a matter for consideration until after 1972, when the Division of Emergency Medical Services was established within the Department of Health. Shortly thereafter a Statewide Plan for Emergency Medical Services was prepared. Identified in this plan for the first time as one of ten major subjects of concern was the categorization of hospital emergency rooms.

In 1973, under a contract with Rhode Island Health Services Research, Inc., (SEARCH) and the now defunct Tri-State Regional Medical Program through a federal grant of $247,000, the development and restructuring of the emergency medical services of Rhode Island was again planned on a much larger scale. This "EMS Planning Project", as it was known, had a multiorganizational Policy Committee composed of individuals from a consortium of health agencies and organizations, supported by many Advisory Committees. One of the advisory subcommittees of the planning project established the framework for implementing categorization of the hospitals in Rhode Island. A detailed study and review of all the information, including criteria, standards, and recommendations of the professional organizations and national conferences mentioned in the preceding paragraphs, was undertaken.

The subcommittee defined three categories of hospital emergency services which it thought would fill the bill for Rhode Island: Comprehensive, Major, and General. These were taken from the recommendations of the conference on Emergency Medical Services of the American Medical Association. Standards as determined by the subcommittee were established for each category. The subcommittee

assisted staff in designing an emergency department questionnaire to assess the level of services provided at that time by each hospital in the state which offered emergency services. The survey indicated that the hospitals in Rhode Island fell into the three categories defined by the subcommittee and they were so identified (Table 1). The subcommittee concluded that one of the most important factors in improving emergency medical care was the providing of information concerning a hospital's staffing and resource capabilities (categorization). This would permit introduction of a policy of taking patients not to the nearest hospital, but rather to the hospital most appropriate for their immediate and future needs.

Table 1. Categorization of Rhode Island Hospitals According to the AMA Designations.

Hospitals	Designated Category
Northern Service Area	
Woonsocket Hospital	Major
Fogarty Hospital	General
Providence-Pawtucket Area	
Rhode Island Hospital	Comprehensive
Roger Williams Hospital	Major
Miriam Hospital	Major
Memorial Hospital	Major
St. Joseph's Prov. Unit	Major
Cranston General	General
Kent Service Area	
Kent County Hospital	Major
South County Service Area	
South County Hospital	General
Westerly Service Area	
Westerly Hospital	General
Newport Service Area	
Newport Hospital	Major

In 1973 the major Federal effort toward improving Emergency Medical Services was the passage of "The Emergency Medical Services Systems Act" (PL 93-154). After overcoming several hurdles, it was signed into law by President Richard M. Nixon in November of that year. It authorized funding for three years of up to 185 million dollars for planning, implementing, and expanding Emergency Medical Services systems in the United States. Further funding was provided by the 1976 and 1979 amendments to the act.

The act had 15 essential components or requirements. One of these was to the effect that an Emergency Medical Servcies system shall "include an adequate number of easily accessible emergency medical facilities . . . which have appropriate non-duplicative and categorized capabilities . . .". Two other important mandated components included in PL 93-154 are closely related to categorization—the requirement of formal transfer agreements between hospitals and the provision of access to specialized critical medical care units. The Division of Emergency Medical Services of the Health Services Administration of the Department of Health, Education, and Welfare was established as the lead agency to coordinate the Federal effort of the Emergency Medical Services Systems Act of 1973. It identified in its published Regulations and Program Guidelines six critical patient groups which demand a competent system for survival, namely, trauma, burn, cardiac, and poisoning victims; high risk infants; and psychiatric drug abuse and alcohol abuse patients.

Following publication of the guidelines the emphasis on categorization took a new turn at the national level. Realizing that very few if any hospitals could provide comprehensive coverage in all of the designated clinical groups, a new more selective approach to categorization was advocated. In the new plan the capability of each hospital was classified according to its resources for providing competent care in each of the above critical care clinical categories. The six clinical groups constitute the 15 per cent truly emergent and 5 per cent life threatening emergencies of all of the 80 million hospital emergency visits annually in which emergency care is sought.

The Rhode Island Department of Health awarded a contract to the nonprofit Health Planning Council of Rhode Island in 1975 to undertake an Emergency Patient Flow Study. The goals of the study were to develop patient flow guidelines, to recommend procedures for implementing these guidelines in the provision of emergency medical services for the critically ill or injured, and to evaluate the potential impact of their use on the emergency care system. A committee knowledgeable in Emergency Medical Services was appointed by the Health Planning Council to accomplish these objectives. The committee, in light of the new national trend in categorization, revised the previous Rhode

Island categorization format, which had classified hospital emergency care capabilities according to the degree of comprehensiveness of the services (Table 1). This was accomplished by reclassifying the hospitals providing emergency services according to their resource ability to treat one or more of the six specific critical clinical groups listed, as required by the Regulations and Guidelines of the Emergency Medical Services Systems Act.

The new categorization format included several additional subdivisions of the six critical care areas. Following the plan adopted by Massachusetts for the Boston hospitals, it also took into account the hospital's capability in determining whether in the case of a given patient 1) to stabilize, admit, and provide definitive care; 2) to stabilize only and transfer the patient; 3) to transfer the patient directly to another hospital (Table 2). The committee with the help of the legal counsel of the Hospital Association of Rhode Island also developed Patient Transfer Agreements, in which those hospitals identified as being able to stabilize, admit, and provide definitive care for an emergency condition (receiving hospitals) would agree to receive patients through a doctor-to-doctor referral arrangement from the emergency departments that stabilize only and transfer for that condition (referring hospitals). Emergency department written transfer agreements are required for certification by the Joint Commission on Accreditation of Hospitals and are required for hospital licensure by the Rhode Island Department of Health.

The report of the Health Planning Council included a retrospective study of emergency admissions. It was determined that patients who were admitted in the course of a year, but not in accordance with the categorization guidelines, and who would or should have been transferred were the guidelines in effect, would have represented only 1.0 per cent of all admissions and 0.9 per cent of patient days on the medical, surgical, and psychiatric services of all the hospitals that were included in the study.

In many areas across the country well-designed categorization programs have been very successful in terms of saving lives. In many instances, however, where statewide classification has been attempted, categorization has remained essentially a "paper" exercise. This applies to Rhode Island. There have been no efforts in this state by the Medical Society, the Hospital Association, the Legislature, or the Department of Health to publicize, implement, or monitor the recommended categorization programs which have been submitted by the planning agencies, although all agree that categorization, if given a chance, can save lives and reduce disability and suffering.

It is important to realize, however, that as of this writing in 1979 the last categorization format (Table 2), which was submitted to the Department of Health in 1977, is very much in need of revision, especially in the case of trauma.

Regional Trauma Center

The hospital resources required for optimal care of the injured patient have been well defined and delineated, most recently by the American College of Surgeons and the Joint Commission on Accreditation of Hospitals. The American College of Surgeons published in their August 1979 *Bulletin* a revised report on "Hospital Resources for Optimal Care of the Injured Patient", which was prepared by a task force of the Committee on Trauma[1]. Three levels of trauma services are suggested. The report indicated that a Level I institution will most likely be a hospital of over 500 beds in a metropolitan area, which has made a large commitment in personnel and equipment to the care of trauma patients. Large university affiliated hospitals with a full compliment of residents in all surgical and most non-surgical disciplines appear best able to provide the exacting in-hospital staffing and service requirements held to be essential for a Level I trauma service. The Joint Commission on Accreditation of Hospitals requires essentially the same standards for Level I institutions as does the American College of Surgeons[2].

It has been well established that a central or regional trauma center based in one hospital will save more lives than decentralized services scattered throughout a number of hospitals — not to mention the duplicative costs for organizing, managing, and staffing more than one major trauma center in a limited geographical area such as Rhode Island. Under the present categorization scheme, seven hospitals are listed as having the same capabilities and resources for handling critically injured patients.

Table 2. Critical Emergency Patient Flow Guidelines. Point-of-Entry Plan for Hospitals with Emergency Rooms in Rhode Island. May 24, 1977.

Point-of-entry code:
1 = Stabilize, admit, and provide definitive care
2 = Stabilize only and transfer
3 = Not a point of entry, patient directed to another hospital

	CONDITION	EMS POINT-OF-ENTRY														
		Fogarty	Woonsocket	Memorial	Cranston	Miriam	Rhode Island	Roger Williams	St. Joseph's OLP	Kent County	South County	Westerly	Newport	Women & Infants	Butler	Institute of Mental Health
I.	**Trauma**															
	A. Severe multiple trauma	2	2	1	2	1	1	1	1	1	2	2	1	3	3	3
	B. Neurosurgical injuries - brain and spinal cord	2	2	1	3	1	1	1	1	1	2	2	2	3	3	3
	C. Major thoracic injury	2	2	1	2	1	1	1	1	1	2	2	2	3	3	3
II.	**Cardiovascular**															
	A. Myocardial infarction, cardiac arrest, and acute congestive heart failure	1	1	1	1	1	1	1	1	1	1	1	1	3	3	3
	B. Complications of above requiring arterial pressures - aortic balloon, catheter lab, and pulmonary bypass	2	2	2	2	1	1	2	2	2	2	2	2	3	3	3
III.	**Poisoning**															
	A. Uncomplicated - not requiring dialysis	1	1	1	1	1	1	1	1	1	1	1	1	3	3	3
	B. Requiring dialysis	2	2	2	2	1	1	2	2	1	2	2	2	3	3	3
IV.	**Burn**															
	Over 30% 2nd and 3rd degree	2	2	2	2	2	1	2	2	2	2	2	2	3	3	3
V.	**Behavioral**															
	A. Psychiatric emergency	2	1	2	2	2	2	2	2	2	2	2	1	3	1	1
	B. Alcohol abuse	2	1	1	1	2	2	2	2	2	2	2	1	3	3	1
VI.	**Neonatal**															
	Under 28 days of age (non-traumatic)	3	3	3	3	3	2	3	2	3	3	3	3	1	3	3

Even a superficial review of the essential criteria for a Level I category hospital as recommended by the American College of Surgeons and the Joint Commission on Accreditation of Hospitals reveals that only the Rhode Island Hospital can fulfill these requirements in Rhode Island. These include availability on a 24 hour basis of medical, surgical, orthopedic, pediatric, anesthesiology, and other clinical services; computerized tomography; and a cardiopulmonary by-pass pump oxygenator, to mention only a few essential criteria. It is recommended that this hospital be designated by the Department of Health as the Regional Trauma Center. This designation would eventually be reached through the process of facility inspection by the Joint Commission on Accreditation of Hospitals, at which time hospitals not meeting the essential requirements for a Level I trauma institution would be certified at a lower level. The urgency of the designation of a Trauma Center does not permit us to go through this process, as further federal funding for Emergency Medical Services in the state is contingent upon the immediate designation of a single Trauma Center for the region.

Further federal funding is most important for the State of Rhode Island, but there is a more significant issue. By establishing a Regional Trauma Center at the Rhode Island Hospital, the commitment by the hospital itself will further provide improved medical services to the critically injured citizens of the state of Rhode Island.

References

1 ACS Committee on Trauma: Hospital resources for optimal care of the injured patient. Bull Amer Coll Surg 64:43-48, Aug 79.

2 Accreditation Manual for Hospitals. Chicago, Joint Commission on Accreditation, 1979.

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Lennert's Lymphoma — Report of a Case with Unusual Presentation and Therapeutic Implications

Unusual Neoplasm Characterized by High Content of Epithelioid Histiocytes Presented in This Case as a Gastric Lymphoma

Robert E. Knisley, MD
Richard P. D'Amico, MD
Joseph DiBenedetto, Jr., MD

Lennert and Mestdagh[1] in 1968 in the German literature described a group of patients thought to have a form of Hodgkin's disease. A second report appeared in the English literature in 1975[2]. Recent authors[3-6] consider these patients to have an unusual form of lymphoma and a distinct clinical entity now referred to as Lennert's lymphoma (LL). The distinguishing feature from the pathologic viewpoint is the high content of epithelioid histiocytes admixed with lymphocytes.

We are reporting a patient with this disorder, who has been followed for almost four years. The presentation as gastric lymphoma has not been previously reported. Therapy is discussed in light of her course and management.

Case Report

AG, a 62 year old white female, was seen in September of 1974 for discomfort in the epigastric region. X-ray studies included an upper gastrointestinal series, which showed some irregularity along the lesser curvature, and a gall bladder series showing evidence of cholelithiasis. In December of 1974, the patient underwent an exploratory laporotomy. A tumor mass was found in the stomach, and several enlarged nodes surrounded the area. A subtotal gastrectomy was performed. The pathology was initially felt to be that of Hodgkin's disease of the mixed cellularity type with involvement of the stomach and adjacent nodes.

The patient was then staged with a chemistry profile, chest x-ray film, intravenous pyelogram, liver and spleen scans, and a lymphangiogram. All of these gave normal results, as did the bone marrow examination. Her serum protein electrophoresis showed a slight elevation in IgG at 2230 with no "M" component. The patient received x-ray therapy consisting

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of 4,000 rads to the gastric bed area. This was delivered between March and April of 1975 in a course of twenty treatments.

Following this therapy, it was felt that the patient might further benefit from chemotherapy, and a course of C-MOPP* was given. She tolerated only small amounts of these medications because of marked marrow suppression. The therapy was changed to prednisone and Cytoxan® in small doses. This therapy was completed in August of 1975, and the patient remained in remission until June of 1976. She then developed repeated episodes of difficulty in swallowing, and a lesion was noted in the right lower peritonsillar area, which was excised. The pathology was similar to that found on prior sections, although typical Reed-Sternberg cells could not be identified. The patient was again evaluated in a staging fashion and found to have no systemic problems or other sites of disease. Treatment consisted of radiation therapy of 4,000 rads to the right and left lateral base of the tongue over twenty-five days. The patient did well until September of 1977, at which time she developed a swelling under the left arm. This node was felt to be pathological and was removed. Microscopically, it was quite similar to her original nodes in the abdomen. She was followed closely, and shortly thereafter a node appeared in the right groin area. This was biopsied and was felt to be probable Hodgkin's disease (or at least consistent with her former biopsies).

She was then admitted to the hospital for evaluation and was found to have some small recurrent lymph nodes in the left axillary area, as well as in the right groin. There was fullness throughout the abdomen, most particularly in the left upper quadrant.

On laboratory study, LDH was elevated at 647. The rest of her chemistry profile was entirely normal, as was a complete blood count. A liver and spleen scan was essentially normal, and the protein electrophoretic pattern was now normal. A bone marrow aspiration and biopsy indicated no abnormality. A chest x-ray film showed prominence in the hilar areas, particularly on the right side, suggestive of mediastinal lymphomatous disease. Ultrasound scan of the abdomen demonstrated a large retroperitoneal mass extending across the midline to the right, but more prominently to the left, consistent with Hodgkin's disease. Bone scan and bone survey were negative. The patient did not allow repeat lymphangiograms.

Figure 1. Gastric Mucosa with Lymphomatous Involvement.

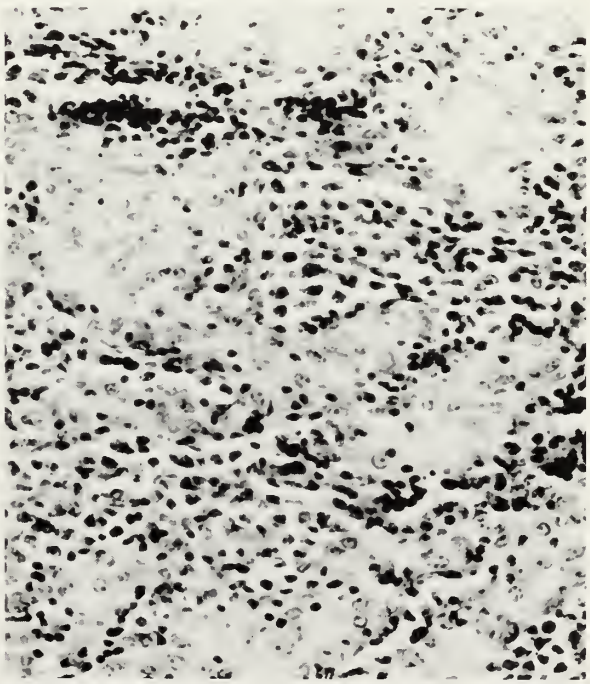

Figure 2. High Power View with Characteristic Epithelioid Histiocytes of Lennert's Lymphoma.

*Cyclophosphamide (Cytoxan®) Oncovin® (vincristine), procarbazine, and prednisone.

At this point, all of the current and past pathology specimens were reviewed and were thought to be consistent with Lennert's lymphoma (Figs 1 and 2). It was then decided to treat the patient again with a program of combination of chemotherapy using lomustine (CCNU), Velban® procarbazine, and prednisone. Initially she showed some improvement on this regime, but then developed severe pancytopenia with a hemoglobin of 6 g percent, platelets of 5,000, and white blood count of 500. Chemotherapy has been discontinued at present, and counts are improving. We feel that she will continue to require chemotherapy, but in smaller quantities.

Discussion

In 1968 Lennert and Mestdagh[1] described a series of patients thought to have a variant form of Hodgkin's disease. The distinguishing feature was a high content of epithelioid histiocytes. These unusual cells are admixed with other cells in a diffuse manner throughout the lymph node with variable-sized lymphocytes simulating a mixed cellularity form of lymphoma in Hodgkin's disease. It is now felt that the distinctive feature of a high content of epithelioid histiocytes warrants identification of a separate entity or a subtype of malignant lymphoma not generally included in the usual classification of Hodgkin's disease.

The initial report in the English literature appeared in 1975,[2] although in a letter to the editor by Robb-Smith[7] a similar patient was apparently recognized some forty years previously and discussed with Lennert in the early 1960s. Within the last several years articles by Burke and Butler[3] and Kim and Dorfman[6], as well as several case presentations[4,5,8] and discussions,[9,10] have appeared and tend to clarify the disorder further. Although early reports have cited the cases as examples of Lennert's lymphoma (LL), recent authors have used the term "malignant lymphoma with high content of epithelioid histiocytes".

There are also clinical features which distinguish the reported patients. The median age is in the 50s and 60s, as opposed to younger ages for Hodgkin's disease. To date no clear-cut sex predominence has been observed, although Kim et al[6] reported more males in their series. The stage of disease at presentation was in the majority of cases widespread with diffuse lymphadenopathy, hepatosplenomegaly, and bone marrow involvement. In many of the reported cases of LL, there has been involvement of Waldeyer's ring when first seen. This is distinctly uncommon in Hodgkin's disease.[11] Concurrent with the advanced stage often noted at presentation were frequent systemic symptoms of fever, sweats, and weight loss. Since many cases presented with an aggressive form of disease, the usual mode of therapy has been varying combinations of chemotherapy with about one third of patients receiving some form of radiation treatment. Median survival averages one to two years with early death frequently related to sepsis.

Our patient presented with a finding not previously reported in LL, that is, a gastric lesion with surrounding positive nodes. This obviously is an uncommon presentation for Hodgkin's disease, which was the original diagnosis in 1974. However, several pathologists reviewed the slides, and the entity of LL was not acknowledged at that time. Interestingly, in a current review of lymphoma cases at Rhode Island Hospital, it was noted that several other patients with LL studied retrospectively originally presented with an abdominal finding.[12]

The peritonsillar involvement, which our patient developed in 1976, has been noted in several of the former reports of LL.[6] In the cases of Hodgkin's disease with involvement of Waldeyer's ring, the histology reported was usually a mixed cellularity form of Hodgkin's disease. It is conceivable that previous reports of Hodgkin's disease may truly have been LL.

Presently our patient has advanced disease with weight loss and evidence of widespread disease. Pancytopenia developed with combination chemotherapy ordinarily used for Hodgkin's disease. It is our current opinion that she should be placed on a lesser program of chemotherapy calculated more for palliation than cure. In view of the considerable number of deaths attributed in the literature to early sepsis, one wonders if such patients should be subjected to aggressive chemotherapy. Certainly with onset at an advanced age, chemotherapeutic drugs in this disorder are less well tolerated then in younger patients.

It is significant that our patient was treated on two occasions with local irradiation with long-term resolution of the disease, which did not recur in treated areas. This effect would tend to point to the efficacy of x-ray therapy, especially for local presentation of LL.

However, at present, there is a paucity of reported cases in which the therapy has been adequately detailed. Thus, a specific therapeutic regime cannot be advised for all patients, until the disease becomes more widely recognized as a separate entity both pathologically and clinically.

Summary

A patient with the recently described entity of Lennert's lymphoma is described. The initial presentation of gastric involvement has not previously been reported. In the light of the patient's course and management, suggestions on therapy are offered.

References

[1]Lennert K, Mestdagh J: Lymphogranulomatosen mit konstant hohem epitheloid-zellegehalt. Virchows Arch Path Anat 344:1-20, 1968 (Ger).

[2]Lennert K, Mohri N, Stein H, et al: The histopathology of malignant lymphoma. Br J Haematol 31 (suppl): 193-203, 1975.

[3]Burke JS, Butler JJ: Malignant lymphoma with a high content of epithelioid histiocytes (Lennert's Lymphoma). Am J Clin Pathol 66:1-9, Jul 76.

[4]Staples WG, Getaz EP: Lympho-epithelioid cellular lymphoma (Lennert's Lymphoma). S Afr Med J 51:555-556, 16 Apr 77.

[5]Tindle BH, Long JC: Fever, lymphadenopathy, and splenomegaly in a 60-year old woman. Case records of the Massachusetts General Hospital. N Engl J Med 297:206-211, 1977.

[6]Kim H, Jacobs C, Warnke RA, Dorfman RF: Malignant lymphoma with a high content of epithelioid histiocytes: A distinct clinicopathologic entity and form of so-called "Lennert's lymphoma" cancer. Cancer 41:620-635, Feb 78.

[7]Robb-Smith AH: Lennert Lymphoma (letter). Lancet 2:970, 30 Oct 76.

[8]MacGillivray JB, MacIntosh WG: A case of Lennert's Lymphoma. J Clin Pathol 31:560-566, Jun 78.

[9]Palutke M, Varadachari C, Weise R, et al: Lennert's Lymphoma, a T-cell neoplasm. Am J Clin Pathol 69:643-645, 1978.

[10]The Lennert Lymphoma. Lancet 2:507, 4 Sep 76.

[11]Todd GB, Michaels L: Hodgkin's disease involving Waldeyer's lymphoid ring. Cancer 34:1769-1778, Nov 74.

[12]Ree J: Personal communication.

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Two Sentence Essay — *"Dilemma"*

In some quarters virtue and patriotism now depend on a willingness to put women into the trenches. Some would serve equality by putting women behind typewriters at headquarters; others are aghast that all male typists would then be sent to the front.

. . . New York Times editorial, "On Sex and the Draft"

Prednisone Therapy of Gold-induced Thrombocytopenia in a Rheumatoid Arthritis Patient

Effectiveness Is Demonstrated in a Case Report

Constantine P. Pagonis, MD

Gold-induced thrombocytopenia is a rare complication of chrysotherapy. It was first recognized in the 1930s, when gold was being used extensively for the treatment of rheumatoid arthritis.[1] Treatment is generally supportive, with the role of corticosteroids and chelating agents remaining controversial.[2] The present case demonstrates the beneficial effect of prednisone in treating this complication.

Report of a Case

A 67-year-old white woman with chronic rheumatoid arthritis refractory to salicylates, Motrin,® and Naprosyn® was started on intramuscular Myochrisine® in injections in December 1977. Initially, she received 50 mg every two weeks for two months, and then 50 mg every four weeks for another two months with dramatic relief of her arthralgias. However, the gold injections had to be discontinued, because the patient developed generalized petechiae and ecchymoses in the upper and lower extremities. The physical examination otherwise was unremarkable. On admission, her laboratory studies were as follows: Hb 12.2 g per cent, Hct 37 per cent, normal blood chemistries, a prolonged bleeding time (8 minutes, 50 seconds), normal prothrombin time, platelet count of 4,000, and negative rheumatoid factor. Bone marrow examination showed normal cellularity of hemopoietic cells. Antinuclear antibody (ANA) at 1/10 dilution was negative, serum agar gel immunoelectrophoresis negative, serum gold 1.2 mg/L, 24-hour urine gold 0.5 mg/d.

Administration of 60 mg of prednisone per day was started and was continued for 3 days, 50 mg for the next three days, and 40 mg for 3 more days. The day after admission the platelet count rose to 8,000, on the fifth day to 80,000, and on the ninth day to 254,000. The patient was then discharged with directions to continue 30 mg of prednisone per day. Two weeks later the platelet count was 223,000, and the petechiae had disappeared. The prednisone was reduced to 20 mg per day, and two weeks later to a maintenance dose of 10 mg per day. Over the next six months the platelets fell to 70,000, at which time the prednisone was increased to 30 mg per day. Within two months, the platelet count reached 210,000. The prednisone was tapered off over the next two months and finally discontinued. In March 1979, eleven months after the thrombocytopenia first manifested itself, the

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platelet count was at 135,000 and by September 1979 the count had risen to 235,000. Interestingly, the patient, as of March 1980, had no arthritic complaints.

Comment

Gold-induced thrombocytopenia is probably due to an immunologic mechanism, even though serum antiplatelet antibodies have not been demonstrated.[3,4] However, shortened Cr 51-labeled platelet survival suggests that the thrombocytopenia is due to excessive platelet destruction.[3] Gold presumably gives rise to an antigen-antibody reaction, and the resulting complex attaches itself on the platelet cellular membranes.[4]

In regard to therapy, prednisone appears to be an effective drug.[4,5] In this case, the patient responded rapidly to prednisone, but had a partial relapse following rapid tapering off. She responded promptly to increased doses of prednisone. A similar experience was reported by Deren.[4] The mechanism of steroid effect has not been clearly established, but it appears that prednisone does not increase gold elimination[6] and that the improvement of thrombocytopenia may be due to suppression of immunologic mechanisms. Chelating agents, such as BAL,® may also be helpful in treating thrombocytopenia in conjunction with prednisone[4] and in severe cases of gold toxicity, or when steroids are ineffective.[7] It appears that BAL® is effective in lowering the gold concentration but not crucial in elevating the platelet count.[4] Splenectomy has been recommended in cases where steroid toxicity develops[4] or when the thrombocytopenia persists in spite of repeated treatment with steroids, but the results of surgery are not consistent.[8] The prognosis for patients with gold-induced thrombocytopenia appears to be favorable if the cumulative gold concentration is not excessive.[9] However, if the patient receives large amounts of gold, bone marrow hypoplasia may develop, resulting in a high mortality.[9]

The present case illustrates the following points: (1) Chrysotherapy should be used with great caution. Special attention should be paid to the total dose of gold as well as to the platelet count while the patient is on therapy and up to 2 years thereafter.[10] A prolonged fall in the platelet count is a warning of toxicity. Gold therapy should be discontinued when this occurs. (2) Prednisone may be highly effective in the treatment of this condition, but it should be continued for a prolonged period to prevent a relapse. Reinstitution of the prednisone at a higher dose is effective in attaining a second remission, thus making possible the eventual discontinuation of the drug.

Acknowledgements

The author wishes to thank Maurice Albala, MD, Paul C. Hessler, MD, Jose A. Galardy, MD, and Miss Leslie Knapp for their helpful advice.

References

[1]Hartfall SJ, Garlend HG, Goldie W: Gold treatment of arthritis: A review of 900 cases. Lancet 2:383-842, 9 Oct 37.
[2]Gibbons RB: Complications of chrysotherapy: A review of recent studies. Arch Intern Med 139:343-346, Mar 79.
[3]Levin HA, McMillan R, Tavassoli M, et al: Thrombocytopenia associated with gold therapy. Am J Med 52:274-280, Aug 75.
[4]Deren B, Masi R, Weksler M, et al: Gold-associated thrombocytopenia. Report of six cases. Arch Intern Med 134:1012-1015, Dec. 74.
[5]Burnstein SL, Staley HL, Calabro JJ: Recovery from aplastic anemia secondary to gold salt therapy (letter). Arthritis Rheum 20:1432-1433, Sep-Oct 77.
[6]Freyberg RH: Gold therapy for rheumatoid arthritis, in Hollander JL, McCarty DJ (eds): Arthritis and Allied Conditions, ed 8. Lea and Febiger, 1972.
[7]England JM, Smith DS: Gold-induced thrombocytopenia and response of Dimercaprol. Br Med J 2:748-749, 24 Jun 72.
[8]Herbst KD, Stone WH, Flannery EP: Chronic thrombocytopenia following gold therapy (letter). Arch Intern Med 135:1622, Dec 75.
[9]Kay AG: Myelotoxicity of gold. Br Med J 1:1266-1268, 22 May 76. Stafford BT, Crosby WH: Late onset of gold-induced thrombocytopenia. JAMA 239:50-51, 2 Jan 78.

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Authority, Freedom, and the Teenager

Our Anxious Times Demand Careful Understanding of Their Values

Reverend Joseph L. Lennon, OP

Parents, teachers and all those involved in high school education worry a great deal about teen-agers. Many books emphasize a common theme: how parents and teachers can get along with teen-agers. This, in itself, is significant. Conditions have so changed that parents and teachers must study ways of adjusting to the demands of adolescents, rather than the other way around.

Numerous recent reports, both literary and scientific, tell us that modern youth are angry young men and women, unsettled, disenchanted with the adult world and with the adults who made and rule it. They are critical of established order and rebellious against those in authority who urge conformity to traditions and customary rules. While such charges were probably just as valid in the Stone Age as in this age of nuclear anxiety, they seem gloomily true to parents and teachers whose own youth becomes more distant and roseate each year.

Delivered at the Annual New England Regional Meeting of the National Catholic Educational Association by Reverend Joseph L. Lennon, OP, Vice President for Community Affairs, Providence College, Providence, Rhode Island.

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A Cult of Rebellion

Much of this attitude may be termed "rebellionism" or pseudorebellion. The teenage cult of rebellion is often, in reality, disguised conformity and false freedom.

Mere disagreement with authorities (whether they be parents, teachers, or clergy) may or may not be legitimate. The rebellion may be only an assertion of independence, a cutting of the apron strings, a smashing of the mold into which Mom and Dad have tried to cram their "little boy." It may be an assertion of autonomy of mind where one, first beginning to think for himself, realizes that Dad does not always know best, that the teacher is not always right, that Sunday school does not answer all the questions. Youth, by nature, are protestants.

Too often a youngster shapes an image of himself as a "rebel," fearless, independent, and bitter. As this self-image crystallizes and becomes rigid, all his thoughts and beliefs must conform to this "rebel image." Nothing can hint of orthodoxy. Anything in the realm of traditional thought is ruled out. He rejects the good with the bad, the truth with the error. He repudiates the Bible along with literalism, and spurns God together with his mistaken notion of God as the Heavenly Policeman.

In a real sense, he has lost his freedom: he cannot choose and distinguish the worthwhile,

the real. He reacts instead of responds. His "new freedom" becomes a type of slavery in which he confuses license with liberty, while he idolizes rebellion for its own sake.

Rebellion vs Independence

Do not confuse, however, the spirit of rebellion with the legitimate search for independence. The desire for freedom among adolescents is basically a desire to develop and unfold the potential for personal growth. Youth needs freedom, but not unlimited freedom; a guiding and directing hand is essential.

The primary task of educational authority is to define and limit the freedom by providing such guidance and direction as is required to obviate insecurity and fear. However, authority that is itself a source of fear and insecurity must not be tolerated in education.

Any well-ordered society (a state, a church, a school) is a balance of freedom and authority. Without freedom, it ceases to be human. Without authority, its order disappears. By excess of either one, both are destroyed. The undisciplined license of a street mob destroys not only authority, but also the freedom of all in its path. Authority and freedom are each needed to preserve the other.

Applied to a school, it means that youngsters should be given as much freedom as possible in keeping with their developing sense of responsibility. Yet limitations on freedom of action are indispensable. Educators who set limits with unambiguous determination are, at times, surprised how positively adolescents react to the establishment of such limits. The presence of limits contributes to a feeling of security.

Teen-agers' search for limits becomes rebellion when adults are too weak or too lazy to establish limits. Quite properly, adolescents interpret the lack of limits as lack of interest or weakness — and they react accordingly. When parents and school authorities fail to establish rules as a situation demands, they deprive the youngster of the valuable opportunity of learning to obey because authority commands.

The school has to face squarely the question of authority and freedom. Education's duty to adolescents is much less the maintaining, than the building up of authority.

The problem has become increasingly difficult in modern times. Because of his immaturity, the youngster does not always see the reasonableness of authority. He is no longer inclined to rely on others. His growing consciousness of increasing strength and approaching adulthood causes him to doubt the claims of authority. As yet, he has not gained sufficient insight to be capable of understanding the necessity and rights of authority. Laws appear to him as willful restrictions imposed by the tyranny of older people; authority as an illegitimate claim of those who use it for their own advantage rather than for the good of their subordinates. That is why authority is one of the things most resented by adolescents.

The problem is complicated by a tendency to confuse rightful authority with authoritarianism — the abuse of authority. To hear some people talk, the exercise of authority is both undemocratic and un-American.

Teachers cede their authority of maturity and knowledge to the immaturity and ignorance of their pupils. The nondirective teacher is hailed as the "more democratic" teacher. Parents fear their children will revolt if they enforce a reasonable curfew or restrict the use of an automobile.

In short, they have failed to inculcate a proper understanding and appreciation of what authority is, of what it does, and how necessary it is for a well-ordered society, whether that society be the home, the school, the community, or the nation.

What is Authority?

Authority is a power regulating conduct. Normally, it is exercised through a command, a law. Someone in authority commands, and others obey. For the perverse, coercion may be necessary; hence there are jails. For the virtuous, persuasion may suffice. Basically, however, authority imposes a moral obligation.

Authority has three functions or roles: pedagogical, directive, and corrective. In its pedagogical role, it points out for the individual at least one correct way of behaving as a human being. It creates the habit of virtue, even though it is obeyed initially through fear. A child may prefer playing to doing his homework, learning how to read, or doing his arithmetic. Yet he had better be made to learn these things if he is ever to improve himself. A young man may hate the rigors of boot camp,

but if he is to become a disciplined soldier, he must pass through the ordeals of training.

If discipline is to be effective so that a man will choose the right things, as a rule it should become a matter of habit, almost from infancy. One cannot wait until the child has reached the age of reason or until the adolescent is in a position to decide for himself, for meanwhile, he may become the victim of bad habits. Bad habits become the true prison for the growing boy or girl. As Aristotle and Aquinas insist, habit must precede reason.

Convention and the Common Good

The moral tone or quality of a community is derived from the habits of its citizens. If a community is to transmit certain habits to its young, it must agree on what habits are desirable. In the literal meaning of the word, it must achieve a convention.

Someone has said that there is only one convention today — that there shall be no more conventions. Yet such extreme individualism would destroy or make impossible the very survival of civilization. What is civilized in most people is precisely that part of them which is conventional. On the other hand, we must avoid conventionalism — the inculcation of habit without freedom and understanding, mere ritualism, going through the motions without reason or enthusiasm.

Rules Are a Means, Not an End

The combining of convention with a due respect for the liberty of the individual involves adjustments of utmost delicacy. Two extremes are equally undesirable. First the convention or rule may be so rigid and minute as to leave little scope for individual initiative. It degenerates into mere formalism. In dealing with youngsters, keep in mind that they deserve freedom commensurate with their maturity. Rules and regulations are *means* to an end, not ends in themselves.

The second extreme is to remove all restraints and rules so youth are left without the standards necessary to stabilize them in a changing environment. They become victims of their own emotions, prey to every passing whim and fancy. Let us insist on the need of conventions, while holding to them flexibly, imaginatively, and progressively.

Authority also has a directive function. This role is so essential, as Thomas Aquinas points out, that even in a society of saints there would be need of law and authority. By nature, man is social, bound to act with others to attain the common good. Good men do so willingly. A catastrophe, for instance, can rally the united effort of complete strangers.

Yet men vary in intelligence, background, and temperament; they are cautious, impetuous, or phlegmatic. In any society, simple or complex, it is difficult to determine precisely what is the common good, and even more difficult to decide on the one best means to attain it. In deciding, wise and good men will differ, because in the human prudential judgment there are always factors uncontrollable and contingencies unforeseen.

In every society, authority is necessary to determine the common good and to specify the one means in which all must unite for its attainment. In a school, the principal or superintendent determines what things are necessary for the welfare and development of students. This is authority's directive role.

Authority's third role is its corrective function. Johnny may not understand the dynamics of his speeding hot-rod. Jane's alcoholic parents may not care where she spends the night. Those who cannot rule and direct themselves must be ruled by others for their own good and the good of society. Society's authority in the person of an official takes over and substitutes his reason for the deficient reason of the insane, the feebleminded, or the immature. This substitutive function of authority is based on the fact that there is some deficiency in the subject which the authority must supply.

Psychology of Authority

Teachers should realize that authority, as such, fails to impress youthful minds. Simply asserting authority makes young people more discontented, more disinclined to listen or obey. A teen-ager is no longer a child who trusts implicitly and obeys without question. Even a child should be asked to obey his parents not because they say so, but because their age and experience qualify them to know better. The adolescent is impressed only when he can be made to see the right and necessity on which authority is based.

Brutal, "authoritative" assertion of authority has an opposite effect on teen-agers. There

are two ways to make authority acceptable to the adolescent: on a personal basis or because its true meaning is approved by reason.

To appeal to a child on a personal basis is risky business. The teacher who says in effect, "Obey me or I won't like you," is asking for trouble. Emotional factors or accidental circumstances may disturb or destroy even the most firmly established personal relationship; then the authority connected with it vanishes. However, the youngster who understands the meaning and necessity of authority has a certainty that is independent of time, circumstances, or personality.

Granted this is a difficult concept to get across to youngsters. In the concrete situation, one cannot divorce the job from the person who holds the job. They go together. That is why authority is weakened most by those who abuse it, who use it for selfish ends rather than for the good of those over whom they are placed. Even children will not accept authority without some questioning. In their eyes, authority must justify and live up to its demands. As a parent complains in verse:

I once was in my children's eyes
The sage who never lacked replies
But now they've entered learning ways
They're passing through another phase
And their astonishment is tall
That I know anything at all.

Perhaps the highest concept of authority is found in the title of the Pope, *Servus Servorum Dei,* "The Servant of the Servants of God." The purpose of any authority, even the highest, is *to serve.*

"In Loco Parentis"

The teacher's task is to steer a middle course between two, equally bad, extremes. He neither must exaggerate authority so as to make it disgusting to the adolescent, nor must he dispense with it, thereby failing to develop a true sense for authority and order.

School personnel stand *in loco parentis.* This concept of teachers being parent surrogates is not popular today. But the philosophy of substitute parenthood is a powerful help to educators in achieving school goals. It can be a force for the orderly, progressive emancipation of students.

The school acting *in loco parentis* should follow the example of the wise and prudent parent who gives freedom and privilege according to the ability of the child to regulate his own behavior and look after his own welfare. In establishing regulations, differences among students in age, intelligence, and general maturity should be considered. Rules that apply to freshmen do not necessarily apply to seniors.

Difficulty occurs when the school imposes a code of discipline or exacts a standard of behavior that parents themselves do not demand of their children in the home. Variances in standards between home and school are most commonly concerned with drinking privileges, use of a car, curfew rules, and wearing apparel.

What does a school do in such circumstances? In my opinion, obligations to the community force school officials to act in such a way as to protect youth from itself, whether or not the parents appreciate the importance of this protection. Too much is at stake in the lives of these young people to allow the leniency of parents to wreck them. A school is blamed if its students are caught in the meshes of alcoholism or narcotic addiction. The concern isn't just the scandal to be avoided, but the damage done to young lives and to society as a whole.

If parents are not willing to assume their parental responsibilities, or if they refuse to set limits to the behavior of their children, then it devolves on the school as a representative of the community to assume this parental function. That is why there is greater need today than ever before for better relations between parents and schools on all levels.

Our schools are engaged in the noble enterprise of building character as well as training minds. This task can be accomplished only when a proper balance is maintained between authority and freedom. When young people begin to see that freedom entails responsibility, when they begin to lead their lives according to the principles and rules of a mature philosophy of life, then they are progressing toward the goal of responsible adulthood. Teachers and parents can perform no greater service to our youth, to our community, and to our nation than to take part in the formation of free, honest, and dutiful citizens.

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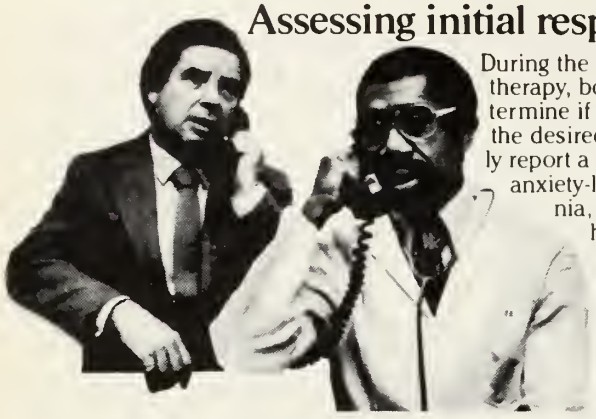
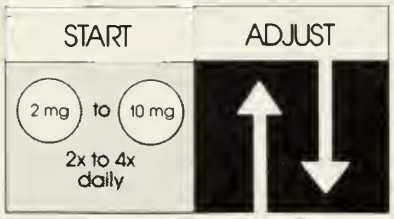


Assessing initial response to therapy

During the first follow-up visit after initiating therapy, both physician and patient should determine if Valium (diazepam/Roche) is having the desired effect. Most patients will promptly report a feeling of relaxation and relief of anxiety-linked symptoms such as insomnia, headaches, palpitations and hyperventilation. You will probably observe that the patient is calmer and more relaxed. If, however, patient response does not measure up to expectations, a reevaluation of the patient's profile with modification of the dosage regimen should be considered.

Making dosage adjustments



With any psychoactive medication it is good medical practice to initiate therapy at base dosage levels and titrate to the patient's needs. With Valium, experience has shown that 5 mg t.i.d. is usually sufficient although some patients with severe or persistent anxiety may require higher dosages initially. In geriatric or debilitated patients, the recommended dosage is 2 to 2½ mg once or twice daily. When anxiety fluctuates, as is common with most patients, the dosage may be adjusted as needed during the course of therapy; three strengths in scored tablets give you unmatched flexibility and simplicity in individualizing dosage.

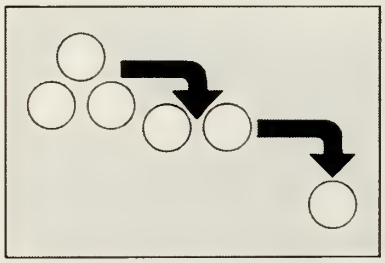
Evaluating progress toward therapeutic goals

SET GOALS						
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	31		

At the beginning of therapy it is now common practice for both physician and patient to establish treatment goals and to estimate the amount of time needed to achieve them. Then the patient knows what to expect and when to expect it. Some physicians find that compiling a checklist of presenting symptoms and complaints is useful for assessing the patient's response from visit to visit. In this way, progress toward attainment of the therapeutic goal is reviewed at regular intervals. As patients feel their symptoms abate and begin to develop insight into the sources of their anxiety and psychic tension, the checklist can be expected to dwindle.

Discontinuing pharmacologic intervention

When you decide to discontinue therapy, tapering dosage is good medical practice. Although rarely necessary after short-term treatment with Valium, gradual dosage reduction is advisable for patients who have been on extended therapy. This gradual discontinuance should preclude either recurrence of pretreatment symptoms or development of untoward side effects. Symptoms of withdrawal have almost always been associated with abrupt discontinuance of therapy at higher dosages taken continuously over long periods of time.



2-mg, 5-mg, 10-mg scored tablets

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diazepam/Roche

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ROCHE®

See the following page for a summary of product information.

Valium® (diazepam/Roche) ℞

Before prescribing, please consult complete product information, a summary of which follows:
Indications: Tension and anxiety associated with anxiety disorders, transient situational disturbances and functional or organic disorders, psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation, symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal, adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy)
The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.
Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.
Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.
Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice, periodic blood counts and liver function tests advisable during long-term therapy.
Dosage: Individualize for maximum beneficial effect. *Adults*: Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients*: 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children*: 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).
Supplied: Valium® Tablets, 2 mg, 5 mg and 10 mg—bottles of 100 and 500; Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Paks of 50, available in trays of 10.

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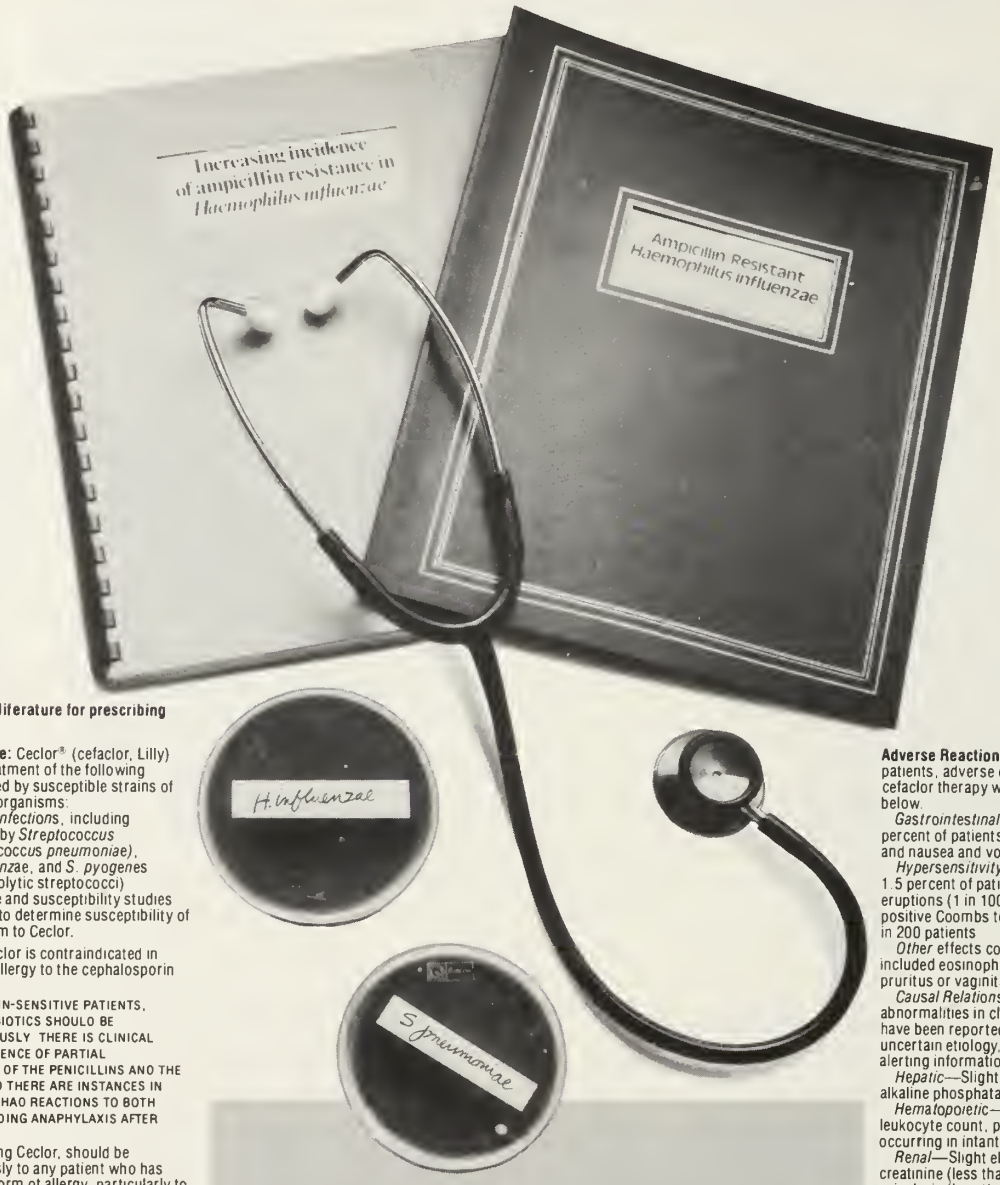
An added complication... in the treatment of bacterial bronchitis*


Increasing incidence of ampicillin resistance in Haemophilus influenzae
Ampicillin Resistant Haemophilus influenzae
H. influenzae
S. pneumoniae

Some ampicillin-resistant strains of Haemophilus influenzae—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Ceclor.[1-6]

In clinical trials, patients with bacterial bronchitis due to susceptible strains of Streptococcus pneumoniae, H. influenzae, S. pyogenes (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Ceclor.[7]

Ceclor®
cefaclor
Pulvules®, 250 and 500 mg

Brief Summary.
Consult the package literature for prescribing information.

Indications and Usage: Ceclor® (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae (Diplococcus pneumoniae)*, *Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci)

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor.

Contraindication: Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS TO BOTH DRUG CLASSES (INCLUDING ANAPHYLAXIS AFTER PARENTERAL USE).

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Precautions: If an allergic reaction to cefaclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of cefaclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs test may be due to the drug.

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such a condition, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

Usage in Pregnancy—Although no teratogenic or antifertility effects were seen in reproduction studies in mice and rats receiving up to 12 times the maximum human dose or in ferrets given three times the maximum human dose, the safety of this drug for use in human pregnancy has not been established. The benefits of the drug in pregnant women should be weighed against a possible risk to the fetus.

Usage in Infancy—Safety of this product for use in infants less than one month of age has not been established.

Adverse Reactions: In clinical studies in 1493 patients, adverse effects considered related to cefaclor therapy were uncommon and are listed below.

Gastrointestinal symptoms occurred in about 2.5 percent of patients and included diarrhea (1 in 70) and nausea and vomiting (1 in 90).

Hypersensitivity reactions were reported in about 1.5 percent of patients and included morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs tests each occurred in less than 1 in 200 patients.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain—Transitory abnormalities in clinical laboratory tests results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic—Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200). [070379R]

* Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.[8]

Note. Ceclor® (cefaclor) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

References

1. Antimicrob. Agents Chemother., *8*:91, 1975.
2. Antimicrob. Agents Chemother., *11*:470, 1977.
3. Antimicrob. Agents Chemother., *13*:584, 1978.
4. Antimicrob. Agents Chemother., *12*:490, 1977.
5. Current Chemotherapy (edited by W. Siegenthaler and R. Luthy), II: 880. Washington, D.C.: American Society for Microbiology, 1978.
6. Antimicrob. Agents Chemother., *13*:861, 1978.
7. Data on file, Eli Lilly and Company.
8. Principles and Practice of Infectious Diseases (edited by G.L. Mandell, R.G. Douglas, Jr., and J.E. Bennett), p. 487. New York: John Wiley & Sons, 1979.

Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285

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000482

June 1980
Volume 63, Number 6

Rhode Island Medical Journal

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Single copies $1.00-Subscriptions $10.00 per year (Members of the Rhode Island Medical Society, $5.00 annually), Second Class postage at Providence, Rhode Island
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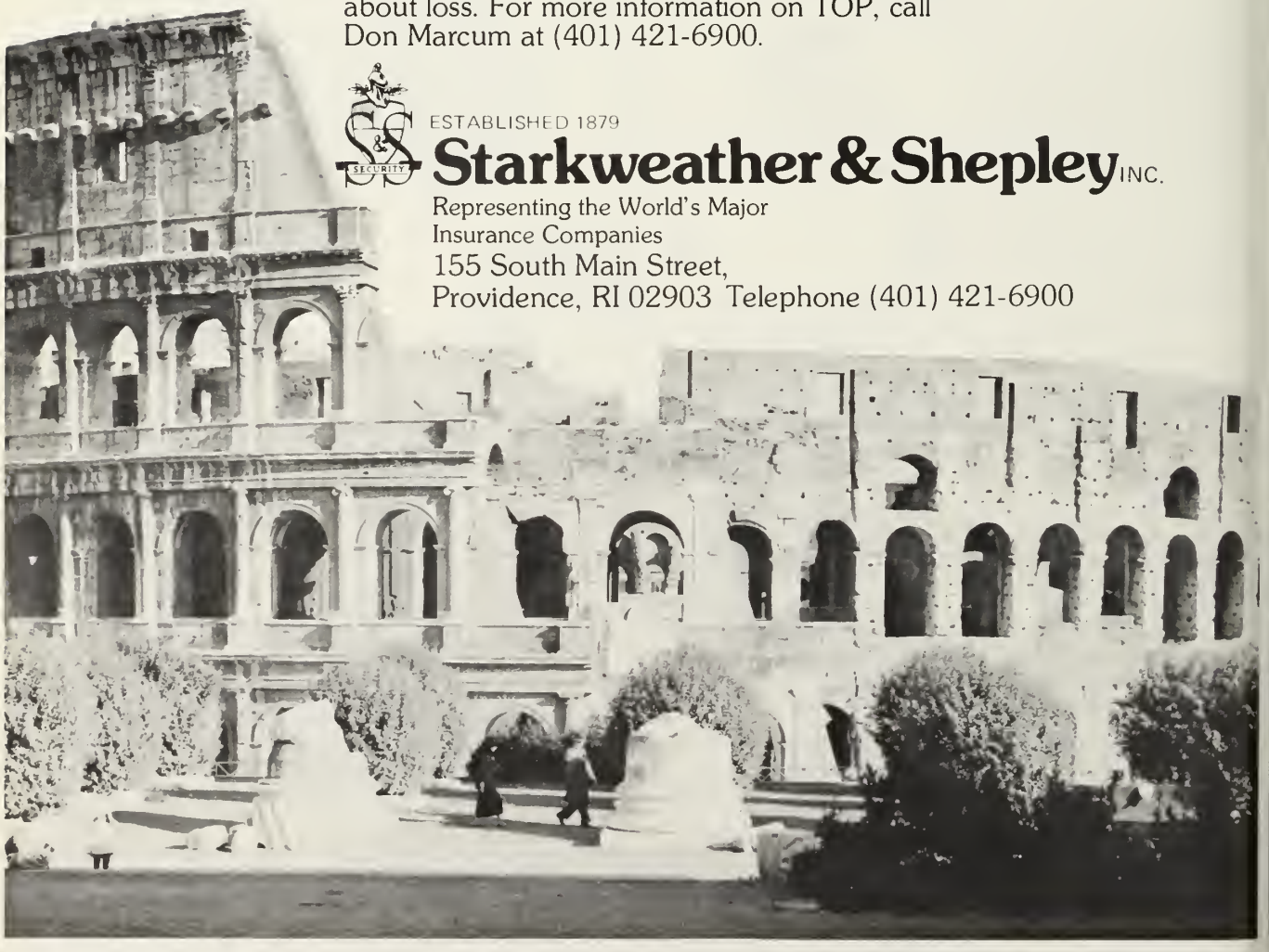

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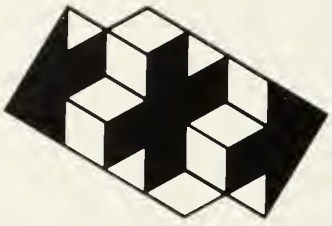
NEWSLETTER

COVER

Photo taken at the ceremonies for the first graduating class of the Brown University Program in Medicine, June 2, 1975, in the First Unitarian Church of Providence, 1 Benevolent Street, Providence, Rhode Island.



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lode Island Medical Society June 1980

lewsletter

James R. Clarkin, Editor

Auxiliaries Carry the Ball

The Annual Meeting of All Rhode Island County Auxiliaries was held on April 29th at the Kirkbrae Country Club in Lincoln. Each year this event draws together auxiliary members from around the state, the location rotating between the four districts, Providence, Kent County, Newport County, and Woonsocket District. This year's host county was Woonsocket. The affair was organized by Mrs. Jean Galardy, President of Woonsocket Women's Auxiliary. About 60 persons attended for a morning business meeting, lunch, and speakers: Leonard S. Staudinger, President, Woonsocket District Medical Society, and Margaret Joyce Diamond, Executive Director, Board of Medical Review.

By the continuous efforts of Mrs. Herbert F. Hager to keep the spirit of auxiliary friendship and volunteerism flourishing, even after the demise of an official state women's auxiliary, there is much going on, presently under the county leadership of Mrs. Galardy, Woonsocket District; Mrs. Alex Arvanitidis, Providence; Mrs. William Van Haaren, Kent County; and Mrs. John Fox, Newport County.

Auxiliary volunteers in cooperation with the state Department of Elderly Affairs will sponsor and spend a day at Rocky Point with elderly citizens on June 23rd. Last year over 200 enjoyed the occasion. Auxiliary volunteers also serve regularly at blood pressure screening centers at Warwick, Lincoln, and Midland Malls.

Mrs. Daniel Calenda is the Rhode Island state liaison with the American Medical Association-Education and Research Foundation (AMA-ERF). Various fund-raising activities enable county groups to contribute to this foundation. Providence's recent Evening at Trinity was a success, raising about $500. Woonsocket has a Christmas card poster tradition, with signees donating $7.50 or $15.00 per couple, which raised over $900 last year.

Mrs. Galardy, questioned what are the main goals of the auxiliary, says, "to help out in the medical community and to promote friendly feelings among families." In this work the auxiliary is a very important, valuable arm to RIMS.

15th POST-GRADUATE CONFERENCE

Medical Aspects of Sports

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Doctors Get Tips on Law and Finance

The importance of "informed consent" and of getting a court order to proceed with treatment in troublesome circumstances. The ways, means, and benefits of incorporation of a private practice. These subjects were discussed in the sessions on "Professional Financial Planning" and "The Doctor and the Judicial Process" of the 8-week course on *Current Legal and Financial Issues for the Practicing Physician.* The sessions are sponsored by Rhode Island Hospital, Department of Orthopaedic Surgery, Brown University Program in Medicine, and the Rhode Island Medical Society. Future topics include "Private Practicing Physicians' Relationship to Third-Party Payors", "The Physician and the Hospital", and "Personal Financial Planning". The sessions are open and there is no registration charge. For more information, call 331-3207 or 331-3208.

Anti-Conflict Calendar:

The Rhode Island Medical Society maintains an on-going calendar of medical meetings and affairs. Call us when you're scheduling — 331-3207 or 331-3208.

What Is "Appropriateness Review"?

Karen Challberg

On Monday, May 12, a public hearing was held at the Rhode Island Department of Health on a "Work Program for State Agency Review of Existing Institutional Health Services for Appropriateness". Dr. Charles E. Millard, President-Elect, presented testimony for RIMS requesting additional time to review the program. The time was granted.

By provision of PL 93-641, it is proposed that reviews of health institutions will be conducted of facilities in fifteen categories during eight six-month time segments beginning with July-December 1980. In the first period the proposed reviews will be of the two services: CT scanners and radiation therapy. For each service a working definition and criteria for "appropriateness" will be developed prior to any review. This will be done by the Division of Medical Care Standards and the Office of Health System Planning, in consultation with the Statewide Health Coordinating Council (SHCC), but apparently without input from other agencies and associations. It is specifically stated in the Work Program that agencies such as the Rhode Island Medical Society, the Hospital Association of Rhode Island, the Brown University Program in Medicine, and RIPSRO will receive advance written notification of specific future reviews "within the following twenty-four months", affording them the opportunity to create study groups or task forces to present independent findings *at the time of review* by the state. In the development of specific criteria, however, these same agencies will not have the opportunity for comment.

The general criteria to be used, as outlined in the Work Program, will relate to availability, accessibility, acceptability, continuity, cost, and quality, with consideration of the relationship of the services being reviewed to applicable recommendations of the State Health Plan and Annual Implementation Plans. There will also be consideration of other factors such as the "availability of alternative uses of resources for the provision of other health services", suggesting the possibility for specific recommendations for reallocation of resources. Consideration will be given also to the "special needs and circumstances of health maintenance organizations", to "special needs and circumstances of biomedical and behavioral research projects which are designed to meet a national need", to the "relationship of services reviewed to the long-range development plan (if any) of the person providing the services", and to other special factors. However, the Division of Medical Care Standards and the Office of Health System Planning will have the sole prerogative for deciding which special factors apply in the development of criteria for review of any specific service.

Reviews will be conducted by the above divisions of the Department of Health, under the supervision of the Office of the Assistant Director for Health Policy. They will be in two phases. The first phase will be statewide review of institutions providing a particular service. The second phase, undertaken when there is deemed to be inappropriateness, in other words when there are deviations from the established criteria, will be "institution-specific reviews". The latter may be system-wide or of only one or more individual institutions.

Costs and accounting procedures of institutions will be looked at carefully. Determinations will be made on the basis of presence or absence of a uniform cost accounting system, unit costs and charges of the service, annual changes in unit costs of the service the amount and distribution of per capita expenditures for the service in the community, and other similar gauges.

Any review could take into its scope a wide range of "affected persons", meaning those "whose service is being reviewed, contiguous health systems agencies health care facilities and health maintenance organizations providing institutional health services any agency which establishes rates for health care facilities or health maintenance organizations, and those members of the public who are to be served by the service subject to review".

The review process will proceed according to the following steps: notification to "affected persons" of the beginning of a review; notification of same to the public by newspaper; completion of "affected persons" of a survey form within 45 days of notification; review of collected information by the regulatory committee of the SHCC; requests for additional information and on-site visits as required. Within 30 days of notification "affected persons" may request an informational public meeting to be held within the first ninety days of a review.

Findings by the state agency will be set down in writing and reports published "regularly". Upon findings, public hearings may be requested within 30 days of the publication of findings, and all written materials pertinent to any state agency review will be accessible to the general public.

Appropriateness reviews are limited to 180 days, but when institution-specific reviews (second phase) are called for, this time limit may be extended indefinitely. Thus, the cost-effectiveness of the review process itself is questionable in a system already laden with expensive safeguards.

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Pawtucket Industry and RIMS Join Forces To Evaluate Health Care Financing

There are many ways to cut back on the costs of health care, without resorting to excessive governmental regulation. This was the message delivered to the Pawtucket Rotary Club on May 1, 1980 by Dr. Peter L. Mathieu, Jr., President, at the businessmen's regular meeting. Dr. Mathieu pointed out that the costs of health care are not rising as fast as costs in other industries, and this is because health care professionals are trying by common sense and creative solutions to make the delivery system's resources work better.

"Businesses have a key role to play, because the policies and plans offered there can dramatically affect utilization by hundreds of employees. Corporations can give too many benefits, and destroy individual incentives for cost-saving in the health area. Doctors can feed this syndrome by recommending longer than necessary absences from work, and unwittingly giving tacit approval to increased health care costs".

At the national level the American Medical Association has been engaged in a "corporate visitation program" to target excesses and weaknesses of health care delivery in individual locations, and to develop the solutions which fit the area. Dr. Mathieu wants to bring this strategy home to Rhode Island. He suggests:

1. Appoint a committee of five from plants and businesses in the area.
2. Study and compare the costs and values of health benefits in the whole spectrum of the area's business concerns.
3. Look for and encourage health insurance plans which offer patient-employee participation, or co-payment, to stimulate individuals' responsibility for costs.

Dr. Mathieu's strongest plea to the Pawtucket Rotarians was to become involved in health cost *planning* — with medical groups, hospital management, insurance companies, labor, the media, and public spokesman. Businesses have a lot of know-how and a lot to offer. "Everyone's involved in the problem and everyone is going to have to work on the solution," he said.

Council Brief

Meeting May 14, 1980
Charles L. Hill, MD, Presiding

In emergency session the Council authorized the Society to proceed to hire an actuary to monitor proceedings of a proposed rate increase of the Joint Underwriting Association (JUA).

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Committee Report: Public Laws

Howard E. Lawton

The Rhode Island Medical Society Public Laws Committee under the chairmanship of Dr. Peter L. Mathieu, Jr. and co-chairman Dr. Peter D. T. Clarisse, held four meetings this year. A total of over 65 bills were reviewed by the Committee at these well-attended meetings. There are 32 members of this very active committee.

There were several bills in which the Society participated in getting passed by the legislature.

Attorney Charles E. Butterfield and Howard E. Lawton, along with several physicians, participated and presented testimony at the various legislative committee hearings.

At a meeting held in the Society office with a legislator and his constituent, a bill was stopped before it was ever presented. A great many of these bills are submitted by constituents because of objection to a single physician, by regulatory boards trying to control doctors' practices, and by groups seeking to enlarge on their programs at the expense of the physicians.

The Rhode Island Medical Society, through the Public Laws Committee, must continue to inform the legislators of its willingness to discuss and assist them in the preparation of any bills in the interest of preserving quality health care for the citizens of Rhode Island.

Note to Readers

The *Rhode Island Medical Society Newsletter* is a monthly insert publication of the *Rhode Island Medical Journal*. It's aim is to provide news of medical and health affairs in our community. Your contributions and comments are welcomed.

Membership Drive Gathers Momentum

One year ago, by vote of the House of Delegates, the bylaws of the Rhode Island Medical Society were revised to provide for medical student, resident, associate, affiliate, and physician's assistant membership categories. Subsequently, a Membership Committee was formed drawing from the whole physician community. A core of government and state MDs, hospital-based MDs, research-based MDs, women physicians, women's auxiliary leaders and others are working now to bring the benefits of RIMS membership to the front.

First and foremost, this is a person-to-person campaign. The Society needs people who want interchange of ideas on common problems, who want activism, who want to be involved in shaping the health care delivery system in Rhode Island in the years ahead.

One of the problems of medical societies all over the nation is the intense competition for physicians' time. In medically-related organizations in other states the squeeze is so tight that physicians are paid for attendance at meetings. There are specialty societies drawing human time and resources, hospital staff groups, PSROs, and in this dense jungle of demands and opportunities the medical society must not be the loser.

The Society is part of an invaluable network with a center in the AMA, from which too many get a free ride. Dr. Peter L. Mathieu, Jr., President, has been on the road trying to change this. In a session before a group of Brown University medical students he pointed out that the AMA is indispensable in the relaying of vital information between states on all kinds of issues affecting medical practice. "We can pick up the phone in Rhode Island and know what is going on regarding negotiations for house affairs in Puerto Rico."

The advantage of the AMA and RIMS is that they are organizations for all physicians. By joining MDs can overcome differences and work out solutions within the "family". Dr. Mathieu stresses, "Fighting is negative energy; communication is positive energy."

In the past weeks the Membership Committee has made presentations to the residents at the VA Medical Center and The Miriam Hospital, to the Brown University Class of 1982, and to the Rhode Island Neurological Society and the Rhode Island Osteopathic Society.

Student members pay no dues; for residents the dues are $35.00. For associate, affiliate and physician's assistant members dues are also $35.00. These fees include a subscription to the *Rhode Island Medical Journal.*

In speaking to the Brown students, Dr. Mathieu said, "I want you to join us and will make this offer — a money-back guarantee. I'll write the check returning your money if you're not satisfied."

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PRESIDENT'S PAGE

We Have Much Work To Do

Thank you for the honor of electing me President of the Rhode Island Medical Society. The President is the official representative and spokesman for the medical profession in the state and, as such, has important responsibilities. It shall be the aim of this administration to study the workings of our Society in depth, to make necessary improvements and changes as needed, and to assure that the Society is responsive to needs of the community, the patient and the doctor.

In this period of changing times the Society's functions are helping to maintain the honor and dignity of our profession.

The Rhode Island Medical Society needs to increase its membership. There are 2,139 physicians in Rhode Island. There are women (198) and men physicians; there are Brown University student physicians (264); there are resident physicians in training in the several hospitals in Rhode Island. There are street physicians (like myself); hospital based physicians; research based physicians; salaried state and federally employed physicians; primary care physicians and specialty physicians. Some of these physicians have trained in the local Brown University program; many have trained in other programs in the United States, and some have trained in many parts of the world. All are physicians and all of these people have much in common, despite their varying backgrounds.

It is in consideration of this common interest that your administration shall direct its greatest effort to aggregate in an organized manner, and to make the physician want to join his or her county medical society, and to make the physician want to join our Society, and to make the physician want to be a member of the American Medical Association.

This administration has formed an Educational and Scientific Board. This board is a subcommittee of the present Continuing Medical Education (CME) Committee. We shall continue to survey and certify CME programs in Rhode Island under the rules and guidelines determined by law and authorized by the Committee on

Standards and Credentials of the Rhode Island Medical Society. This administration will make available a series of CME activities which will be free to members of the Rhode Island Medical Society, scheduled from October through April. We will also sponsor CME excursions outside of the state, which will combine education with the recreation and rest needed by busy physicians if they are to keep up with their multiple responsibilities to profession, family, children and friends.

This administration, through its High Technology-High Touch Committee, shall initiate computerized systems for the Rhode Island Medical Society. The Society of the future will provide individualized learning and self-evaluation programs. It will contribute a service to the medical community by developing and maintaining various data bases. It will provide stable and continuous communications concerning practices and perspectives of concern to us all. At the present time our Society is one of only fourteen medical societies in the country that is not computerizing its records. Planning and systems development will assist the Rhode Island Medical Society in tracing and coordinating membership of our Society, the county societies, the specialty societies, and such other groups as medical students and hospital based physicians, and in responding to the requests for such information received daily by the Society.

Insurance, in particular liability insurance, is another concern of this administration. The recent study done by Johnson & Higgins respecting the feasibility of a Rhode Island Medical Society liability insurance company will be looked at carefully and reported prudently to the membership, with recommendations. The Ad Hoc Committee on Self-Insurance, which led investigations of a private liability company, has been combined with the group of physicians presently serving as physician members on the JUA Board. This action was taken to facilitate the rapid transmittal of all current information on liability insurance to the whole profession. Any insurance company wishing to sell casualty insurance in Rhode Island must be a member of the Joint Underwriting Association (JUA), and there are presently 301 companies writing casualty insurance in Rhode Island, providing a substantial base which needs to be properly monitored and managed.

This administration is concerned about some physicians' discontent with Blue Cross and Blue Shield. We remind you that Blue Shield of Rhode Island was sponsored by the Rhode Island Medical Society forty years ago with the purpose of providing medical-surgical services to the working class people in Rhode Island at a price they could afford. Fifty per cent of the members of the Board of Directors of Blue Shield are physicians appointed by the House of Delegates of the Rhode Island Medical Society. Blue Shield is basically an insurance company and a good one. It has served as a conduit for monies paid largely in the form of premiums by the employer-employee to be distributed wisely for the payment of services delivered by the profession to the patient. Blue Shield has, in addition to the Board of Directors, a Professional Advisory Committee elected by the Rhode Island Medical Society, a hot line for physicians, and several avenues of communication open to the consumer and to the physician for resolution of misunderstandings when they arise.

Has Blue Shield made mistakes? Yes it has. Is it perfect? No it isn't. Is it hard-nosed? Yes it is. Does it listen? Yes it does. As president, I will attend meetings of the Blue Shield Board of Directors, represent the medical profession, and report back to you in a timely manner. We have formed a special Rhode Island Medical Society-Blue Shield Liaison Committee specifically to resolve members' problems when they seemingly are not being heard, and to remain cognizant and vigilant of Blue Shield's operations as a business.

The increasing cost of health care is too complex an issue to address at length at this time. Among the acute problems which we face in Rhode Island is a marked increase in the elderly population, eg 2 per cent above the national average, creating increased costs and demands on our health care system. Medicare legislation (1965) tried to solve some problems of elderly patient care, but failed properly to direct resources and, in particular, did not provide for adequate reimbursement for ambulatory care, extended care, and home health care services.

A Society Committee on Aging working with the Rhode Island Department of Elderly Affairs, the Governor's Commission on Aging, and other public and private citizen groups will actively seek solutions. Home health care and extended care efforts need physicians' guidance. This administration is pledged to make it happen.

The aim of the Rhode Island Medical Journal President's Page in subsequent months will be to inform and to stimulate.

This administration will tell it like it is.

Peter L. Mathieu, Jr., MD
President

EDITORIALS

The Class of '80

In the short history of the Brown University Program in Medicine it has become a tradition for the *Journal* to devote a Spring issue to the graduating class. We welcome them to our pages, as we have in the past.

A considerable portion of this issue is devoted to a series of brief homilies by members of the class. These tell of their trials and tribulations as students, and their joys and anxieties upon entering the profession of medicine. Their almost unanimous expression of devotion to the ideals of medicine and the overweaning importance of the welfare of the patient is profoundly reassuring.

The *Journal* itself as a token of our confidence and as an expression of our desire to have them contribute to our deliberations has added to the Editorial Board a resident and a medical student. We look forward to working with them and having the benefit of their counsel.

Some of the graduates will join hospitals in the Rhode Island area, others will travel afield, and some of these will return later to practice among us. We urge them all, if they have not already done so, to join the Rhode Island Medical Society, or the society where they reside, and the AMA as well, an invaluable umbrella and servant for us all. Both they and medicine will benefit greatly from this participation.

Again, we greet you as you embark upon this noble enterprise.

Doctors and Politics

In these days of increasing involvement in all kinds of medicolegal, social, and political affairs by our Fellows, the following items, found when searching our archives, reminded me that physicians in other years, too, have played roles in the dramas of state.

"Providence, June 29, 1842. The regular annual meeting of the Rhode Island Medical Society was holden this day, in the State House, in Providence, in accordance with the provisions of the By Laws . . . it was voted that the annual meeting . . . stand adjourned till . . . September." (Records: Rhode Island Medical Society).

The reason for the adjournment isn't given, but the Fellows may have felt that the State House might become a battleground. The attack on the Arsenal by a small band of followers of Thomas Wilson Dorr on May 18 marked the beginning of the use of arms in the Dorr Rebellion. By June, martial law was in effect and the troops were much in evidence. (*The Life and Times of Thomas W. Dorr* by Dan King. Boston, published by the author, 1859.)

Doctor Dan King, Fellow of the Massachusetts and Rhode Island Medical Societies, author of several books (*Spiritualism Unmasked, Quackery Unmasked, Tobacco: What It Is and What It Does,* and a "state paper" on the condition of the Narragansett Indians, among other titles), and an active Suffragist, was a friend of Dorr's. "He was opposed to the call to arms. On the whole he so kept the respect of the community, that when the trouble was at its height, though he was quickly arrested by the State's forces as a well-known Dorrite, when he was brought into the "prison" by the capturing party, the officer in charge immediately released him." (*Biographical Sketches of Doctor Dan King and His Sons* by Eugene P. King and Henry King. The Providence Press, Snow and Farnham Printers, 1892, p7.)

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REPORTS OF THE HOUSE OF DELEGATES

Minutes: Meetings, February 27, 1980 and March 26, 1980

A special meeting of the House of Delegates of the Rhode Island Medical Society was held on Wednesday, February 27, 1980 in the auditorium of the Rhode Island Medical Society building.

Members present were: Drs. Charles L. Hill, Herbert F. Hager, James A. McGrath, Peter B. Baute, William S. Klutz, William J. MacDonald, Erminio Cardi, Louis Vito, Jr., Kenneth E. Liffmann, H. Gerald Rock, Richard E. Kuhn, Oscar Z. Dashef, Augustine M. McNamee, P. Joseph Pesare, Richard L. Testa, H. Raymond McKendall, Erwin Siegmund, Daniel Moore, Jr., Betty B. Mathieu, Robert E. Curran, Frank M. D'Alessandro, John J. Coughlin, Charles J. Ashworth, Jr., Joseph E. Caruolo, William F. Varr, Jr., Edward F. Asprinio, Klaus F. Haas, Leonard S. Staudinger, Alphonse R. Cardi, Harry M. Iannotti, Richard W. Perry, Guy A. Settipane, Robert A. Indeglia and Catello Scarano.

Also present were: Atty. Charles E. Clapp, II, Legal Counsel; John Schroeder, Vice President, Johnson & Higgins; Judith Pollard, Thomas Hardy, Staff, Johnson & Higgins; Howard E. Lawton, Karen Challberg, Jim Clarkin, Staff, Rhode Island Medical Society.

The meeting was called to order at 2:20 pm by the Speaker, Dr. Leonard S. Staudinger. He, in turn called upon the President, Dr. Charles L. Hill.

Dr. Hill apprised the House that this meeting had been called for the sole purpose of discussing and deciding the course to be taken by the Society relative to the formation of a physician owned insurance company. A study of this subject resulted because of expressed dissatisfaction by many members with the Joint Underwriting Association (JUA), and the vote by the House of Delegates to make a $20 member assessment to conduct a feasibility survey.

Dr. Hill said, "At no time has there been any intent to supplant the JUA with a physician owned insurance company. We are looking for the strengths of each and hope these will be discussed this afternoon. Such a company, if it were to become a reality, might offer an alternative and create an atmosphere of healthy competition with the JUA."

"This meeting affords the proponents of either the JUA or a physician owned company an opportunity to discuss the pros and cons in a calm logical manner. It will then be the responsibility of the House of Delegates to determine, by vote, either to continue further with the matter or no longer to pursue the subject."

Mr. John Schroeder, Vice President of Johnson & Higgins, apprised the House of the updated survey results (643 responses, representing 55 per cent of the Rhode Island Medical Society membership), which indicate that approximately 88 per cent of the total responses support a physician owned company. Additionally, he explained a modified claims policy versus an occurrence policy, and exhibited tentative rates for the various classes of policies, noting that JUA data had been utilized in these determinations.

Considerable discussion took place relative to the advantages and disadvantages of the JUA and a physician owned company, respectively.

Dr. H. Gerald Rock, a physician member of the JUA Board of Directors, presented in brief form six problems associated with the formation of a physician owned insurance company. These were:

1) Capitalization: The Director of the Department of Business Regulation has stated that $3,000,000 will be required. If 500 MDs were to join the company, each would have to ante up $6,000 to capitalize the company.

2) The Director also has stated that if the company were not adequately capitalized, then each policy would be assessable. This would mean that if the company did not do well financially, then each MD would be assessed up to five times the amount of his premium to keep the company solvent.

3) Will reinsurance be enough to keep a small private insurance company financially stable in a very adverse market? Reinsurance companies are noted for doubling or tripling their rates if the company is not doing well.

4) The claims made premium is supposed to represent 20 per cent of the occurrence premium.

If this is so, the premium for the occurrence rate offered by the doctor's insurance company would be more than twice what the JUA is now charging.

5) If this company were to be formed, what would happen to the JUA? Will it become a high risk pool for those doctors rejected for participation in the doctor's insurance company?

6) Is peer review a proper function of a malpractice insurance company? Should MDs be relegated to the high risk pool because of age, volume of practice, or difficulty of procedures performed?

Dr. Rock added, "The present JUA is already capitalized, does not have an assessable policy, is stable because it is supported by all the insurance companies in Rhode Island licensed to sell casualty coverage."

"It does not need reinsurance. The premium charged now is about 50 per cent of that proposed by the doctor's insurance company. All doctors are equally insured by the JUA, no one is denied participation."

Mr. Schroeder responded, in part, by declaring that if the Commissioner required an assessable policy, he would immediately advise the Society not to consider the formation of a physician's company. With respect to reinsurance, he advised that three companies writing this type of business have expressed genuine interest and willingness to provide reinsurance if the company were to be formed. This would be accomplished by treaty agreements between the parties.

In the case of the so-called "high risk" physician, the company's Board of Directors, composed of physicians, fortified by an administrative staff of insurance professionals (actuaries, claims examiners, and others) would determine the criteria to be established. The Underwriting Review Board (physicians) would play an important role in effective underwriting control.

A request was made that the physician members of the JUA submit reports (quarterly) to the membership through the *Newsletter* or this *Journal* in layman's language. This was countered by a request that physicians advise the Board members relative to ways in which the JUA might save money, offer better services, or modify its operation.

It was agreed that three options were available:

1) To proceed no further with respect to forming a physician owned insurance company.

2) To obtain a charter and proceed to form a company.

3) To obtain a charter, but negotiate to modify the JUA; and then continue to proceed exploring a physician owned company if the JUA negotiations were to be unsuccessful.

Action: A motion was made, seconded and voted that the House of Delegates of the Rhode Island Medical Society affirms support for the enactment of legislation for the purposes of obtaining a charter for a physician owned mutual insurance company domiciled in the State of Rhode Island, provided it is a viable alternative to the present sources of medical malpractice liability insurance.

This action was passed by a vote of 12 in favor, 8 against.

There being no further business the meeting was adjourned at 4:20 pm.

Respectfully submitted,

James R. Clarkin
Executive Director
(in the absence of the Secretary,
Dr. Melvin D. Hoffman)

A **regular meeting** of the House of Delegates of the Rhode Island Medical Society was held on Wednesday, March 26, 1980 in the auditorium of the Rhode Island Medical Society.

The meeting was called to order by the Vice-Speaker of the House, Dr. Charles P. Shoemaker, Jr., at 2:10 pm. Members present were:

Officers: Charles L. Hill, MD, President; Melvin D. Hoffman, MD, Secretary

Immediate Past President: Joseph E. Caruolo, MD

Delegates:

Kent County Medical Society: William F. Varr, Jr., MD

Newport County Medical Society: Charles P. Shoemaker, Jr., George P. Lewis, Jr., MDs

Pawtucket Medical Association, Inc.: Richard E. Kuhn, MD

Providence Medical Association: Alphonse R. Cardi, Frances P. Conklin, John J. Coughlin, Frank G. DeLuca, Herbert F. Hager, Harry M. Iannotti, William S. Klutz, Mary D. Lekas,

Thomas R. Littleton (substitute for H. Raymond McKendall), Betty B. Mathieu, Anthony F. Merlino, Julius C. Migliori, Daniel Moore, Jr., Kenneth B. Nanian, Herbert Rakatansky, Robert W. Riemer, Barbara H. Roberts, Guy A. Settipane, Richard L. Testa, Joseph R. Tucci, Louis Vito, Jr., MDs

Washington County Medical Society: Erwin Siegmund, MD

Woonsocket District Medical Society: Orazio Basile, MD

Specialty Society Representatives: Rhode Island Society of Internal Medicine, Frank P. Duffy, MD; Rhode Island Section, American College of Obstetricians and Gynecologists, John J. Coughlin, MD; Rhode Island Society of Allergy, Guy A. Settipane, MD; Rhode Island Chapter, American College of Surgeons, Paul J.M. Healey, MD

District Society Presidents: Providence Medical Association, Daniel Moore, Jr., MD

Members Ex Officio: Seebert J. Goldowsky, MD, Editor, *Rhode Island Medical Journal;* Herbert F. Hager, MD, Alternate Delegate, American Medical Association; William J. MacDonald, MD, Chairman, Rhode Island Blue Shield

Vice-Speaker: Charles P. Shoemaker, Jr., MD

Also Present: Karen Challberg, Jim Clarkin, staff members

Members absent were:

Officers: James A. McGrath, MD, Vice President; Peter L. Mathieu, Jr., MD, President-Elect (excused); Melvyn M. Gelch, MD, Treasurer (excused)

Delegates:

Bristol County Medical Society: Leonard J. Parker, MD

Kent County Medical Society: Peter B. Baute, Klaus F. Haas, James R. Hagerty, Richard W. Perry, William A. VanHaaren, MDs

Newport County Medical Society: Edwin Singsen, MD

Pawtucket Medical Association, Inc.: Robert S. Burroughs, Robert E. Curran, David R. Hallmann (excused), Nathan Sonkin, MDs

Providence Medical Association: Charles J. Ashworth, Jr. (excused), Michael S. Barrett, Joseph P. Bellino, Bernard J. Berstein, Thomas G. Breslin (excused), Erminio Cardi, George N. Cooper, Jr. (excused), John E. Farley, Jr., Robert A. Indeglia, Jerry M. Kheradi (excused), Joseph P. Lombardozzi (excused), Richard T. McDermott, H. Raymond McKendall (excused), Robert G. Rosenberg (excused), Rajnikant K. Shah (excused), Louis V. Sorrentino, Hugo Taussig (excused), Raymond W. Waggoner, MDs

Washington County Medical Society: Robert E. Knisley, Louis A. Morrone, Douglas A. Rayner, MDs

Woonsocket District Medical Society: Oscar Dashef, E. James Monti, Catello T. Scarano, MDs

Specialty Society Representatives: Rhode Island Orthopedic Society, A. Louis Mariorenzi, MD; Rhode Island Radiological Society, Royal C. Hudson, Jr., MD; Rhode Island Chapter, American Academy of Pediatrics, John E. Farley, Jr., MD; Rhode Island Society of Pathologists, Inc., William Q. Sturner, MD; Rhode Island District Branch, American Psychiatric Association, Louis Hafken, MD; Rhode Island Society of Anesthesiologists, Augustine M. McNamee, MD (excused); Rhode Island Emergency Room Physicians, Robert L. Conrad, MD; Rhode Island Chapter, American Academy of Family Physicians, Charles E. Millard, MD; Rhode Island Dermatological Society, Bencel L. Schiff, MD; Rhode Island Ophthalmological Society, Samuel V. Just, MD; Rhode Island Otolaryngological Society, Stephen A. Issenberg, MD; Providence Surgical Society, George T. VanPetten, MD; Rhode Island Society of Neurosurgery, Walter C. Cotter, MD; Rhode Island Society of Nuclear Medicine, Ben C. Claunch, MD; Rhode Island Thoracic Society, John A. Pella, MD

District Society Presidents: Bristol, Alexander N. Arvanitidas, MD; Kent, James R. Hagerty, MD; Newport, Peter D.T. Clarisse, MD; Pawtucket, David R. Hallmann, MD (excused); Washington, Henry B. Freye, MD; Woonsocket, Leonard S. Staudinger, MD (excused)

Members Ex Officio: Joseph E. Cannon, MD, Director, Rhode Island Department of Health; John J. Cunningham, MD, Delegate, American Medical Association.

Approval Minutes

The Vice Speaker noted that the minutes of the January 30, 1980 meeting had been printed and distributed by the Secretary.

Action: A motion was made, seconded and voted that the minutes of the January 30, 1980 meeting be approved and placed on record.

The Vice Speaker noted that the minutes of the

February 27, 1980 special meeting had been printed and distributed by the Secretary.

Action: A motion was made, seconded and voted that the minutes of the February 27, 1980 special meeting be approved and placed on record.

Report of the Secretary

The Speaker noted that the report of the Secretary was contained in the handbook and those items of an informational nature would not require discussion unless a request was made to do so.

Items numbered 1, 2, 3, 4, 6, 10, 11, 12, 14, 16, 17, 19 were approved without discussion.

7) *SHCC*

Dr. Hill apprised the House of Delegates of the present relationship between SHCC and the health providers. He noted that discussions with Department of Health personnel, the health planners and Dr. Carleton have resulted in the deletion or modification of many of the elements in the plan, making it more acceptable to the physician population.

Dr. Caruolo advised that while the plan appears to be compatible with the physicians' viewpoints, it must be remembered it is not "set in concrete" and can be changed during any review period. The annual implementation process must be carefully watched.

8) *Physician Owned Insurance Company*

Dr. Louis Vito, Chairman of the Committee on Self-Insurance reported that a bill had been introduced in the General Assembly calling for the granting of a charter which would allow the formation of a physician owned insurance company, if and when this decision is made. Johnson & Higgins, meanwhile, is compiling additional data which would be required by the Commissioner of Business Regulation if a decision for implementation is made.

9) *CME Relicensure*

Dr. Herbert F. Hager, Chairman of the Committee on Standards and Credentials reported that during the recent relicensure period under the mandated CME requirements, the Department of Health mailed out 2027 applications. Of this number, 1898 were returned and only 12 physician applicants failed to meet the CME requirement of a minimum of 60 documented credits over the three-year period. Six of these were out-of-state applicants and the remaining six were non-active physicians.

10) *Student and Resident Members on Committees*

The Council's recommendation that a student member and a resident member be placed on each of the Society's committees was modified by the House of Delegates.

Action: A motion was made, seconded and voted that one student member and one resident member be placed on each of the Society's committees *at the discretion of the Council.*

Report of the Treasurer

Action: A motion was made, seconded and voted that the report of the Treasurer as submitted be approved and placed on file subject to audit.

Recommendations from the Council

1) *Slate of Officers and Standing Committees*

Action: A motion was made, seconded and voted that the Secretary cast one vote indicating the House of Delegates' approval of the slate for President, President-Elect, Vice President, Secretary and Standing Committees by the Council.

The Council recommended two nominees for Treasurer. Ballots were distributed in order that a nominee for this position could be determined by majority vote. Dr. Erminio Cardi was nominated as Treasurer.

Action: A motion was made, seconded and voted that as indicated by the majority vote Dr. Erminio Cardi be designated as the nominee for the office of Treasurer.

2) *Resolutions*

Action: A motion was made, seconded and voted that the House of Delegates of the Rhode Island Medical Society approve the resolution presented by Dr. Peter L. Mathieu, Jr. recommending the candidacy of H. Thomas Ballantine, Jr., MD to become President-Elect of the American Medical Association in July 1980.

Action: A motion was made, seconded and voted that the House of Delegates of the Rhode Island Medical Society approves the resolution presented by Dr. Peter L. Mathieu, Jr. that the President appoint a committee to study the structure of the administrative staff of the organization and report his findings and recommendations to the Council of the Rhode Island Medical Society for study and implementation at the June 1980 meeting of said Council.

New Business

1) *Proxy Provision*

A motion was made that a committee be appointed to establish a proxy provision for the

House of Delegates. This motion was defeated.

2) *Revision of Bylaws*

A motion was made that a committee be formed to revise the Bylaws. This motion was not seconded.

3) *Rhode Island Medical Journal*

Dr. Hill commended Dr. Guy A. Settipane, Chairman of the Publications Committee, its members and Dr. Seebert J. Goldowsky, Editor, for the "new look" and improved content of the *Journal,* noting its vital link between the Society and the membership-at-large.

4) *Dr. Melvyn M. Gelch*

Dr. Hill noted that although he had expressed tribute previously to Dr. Gelch for his outstanding work as Treasurer of the Society, he felt compelled at this his last meeting of the House of Delegates as President to again acknowledge the gratitude of the Society for Dr. Gelch's reorganization of the financial structure resulting in substantial increase in income through professional management.

Reports of Committees (written)

The Vice Speaker noted that the committee reports contained in the handbook were for informational purposes only and did not require any specific action by the House.

Action: A motion was made, seconded and voted that the written reports of the following committees, as submitted to the House, be received and placed on record: CME Committee, Drug Abuse Committee, Library Committee, Committee on the Medical Aspects of Sports, Publications Committee, Committee on Self-Insurance, Committee on Standards and Credentials and the Physicians and Carriers Workmen's Compensation Committee.

Reports of Committees (Oral)

Dr. Melvin D. Hoffman, Chairman of the Mediation Committee reported that his committee has reviewed over 100 cases per year. Most complaints dealt with dissatisfaction with a physician's charge and inability to communicate with the physician. Occasionally, the committee has not been able to process a complaint because of lack of response from the involved physician. This places the committee and the Society in an unfavorable light with the complaining patient, who feels he or she has wasted time, and leaves the impression that the Society is "protecting" the physician.

There are also complaints received against non-member physicians, which has posed a problem for the committee.

Dr. Hoffman noted that upon advice of the Council in the event of no response from a member physician after a reasonable time both the physician and the patient will be informed of alternative sources that might be contacted, including the Board of Medical Review. The same procedure would apply to complaints against non-member physicians.

Commendation of Dr. Charles L. Hill

The Vice Speaker requested a round of applause by the House of Delegates, as indication of appreciation of Dr. Hill's leadership during the past year, noting the positive steps he has taken to revitalize the Society, his efforts to unify the members and his constant attempts, in a public relations sense, to enhance the image of the physician with the public. The House responded with a standing ovation in support of the Vice Speaker's remarks.

Adjournment

There being no further business, the meeting was adjourned at 3 pm.

Respectfully submitted,

Melvin D. Hoffman, MD
Secretary

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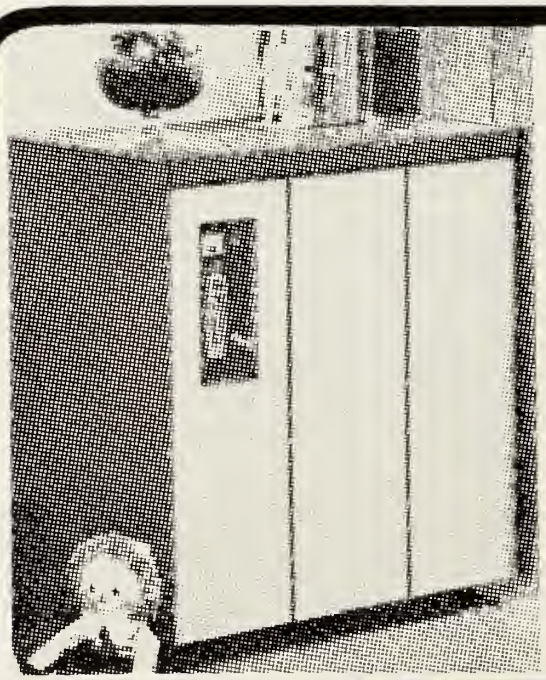

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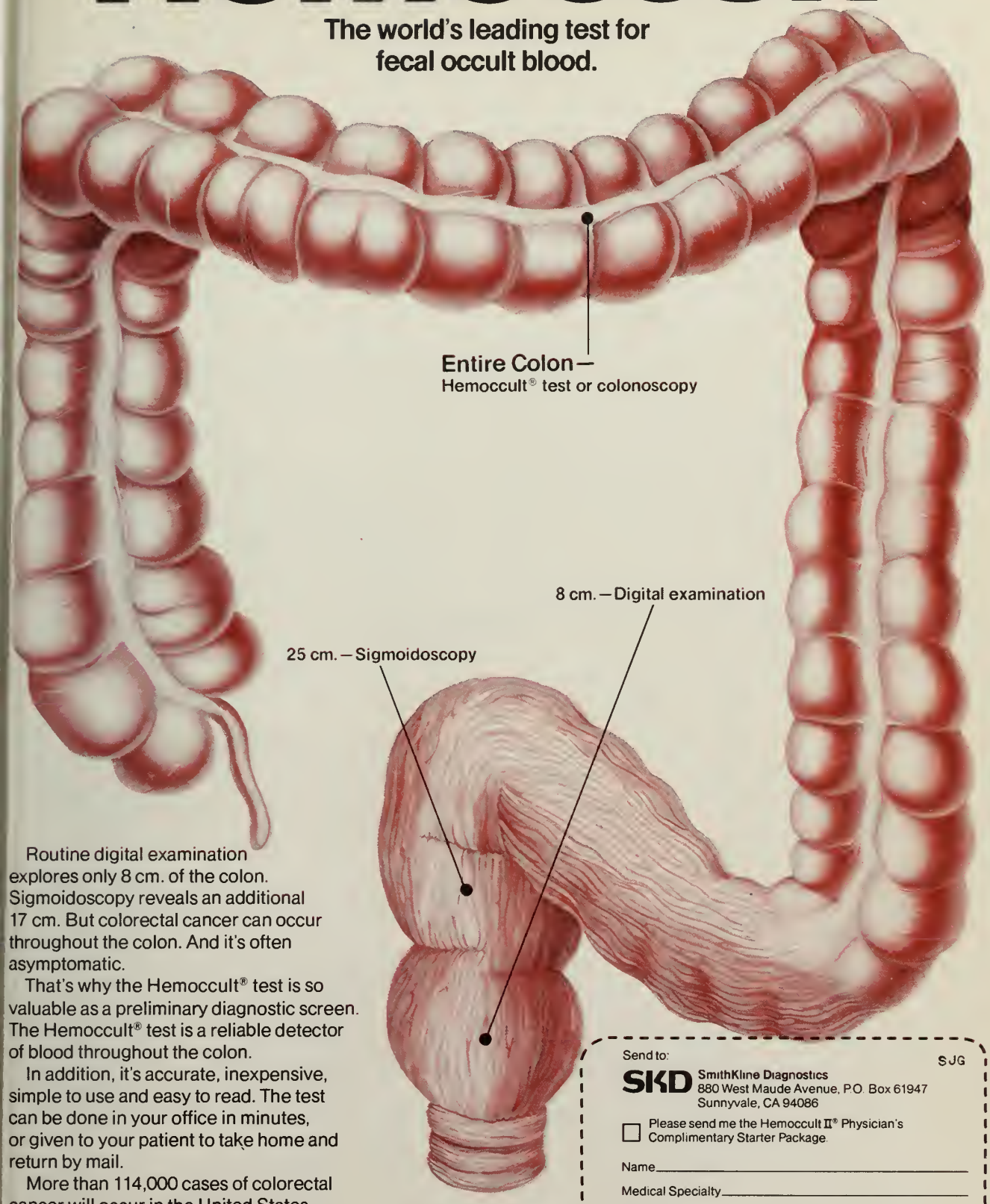

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Perdiem™

Prescribing Information

ACTIONS. Perdiem™ with its gentle action, does not produce disagreeable side effects. The vegetable mucilages of Perdiem™ soften the stool and provide pain-free evacuation of the bowel. Perdiem™ is effective as an aid to elimination for the hemorrhoid or fissure patient prior to and following surgery.

COMPOSITION. Natural vegetable derivatives. A unique blend of psyllium and senna (Plantago Hydrocalloid with Cassia Pod Concentrate).

INDICATION. For relief of constipation.

PATIENT WARNING: Should not be used in the presence of undiagnosed abdominal pain. Frequent or prolonged use without the direction of a physician is not recommended. Such use may lead to laxative dependence.

DIRECTIONS FOR USE—ADULTS. Before breakfast and after the evening meal, one to two rounded teaspoonfuls of Perdiem™ granules should be placed in the mouth and swallowed with a full glass of warm or cold beverage. Perdiem™ granules should not be chewed. After Perdiem™ takes effect (usually after 24 hours, but possibly not before 36-48 hours), reduce the morning and evening doses to one rounded teaspoonful. Subsequent doses should be adjusted after adequate laxation is obtained.

IN OBSTINATE CASES: Perdiem™ may be taken more frequently, up to two rounded teaspoonfuls every six hours.

FOR PATIENTS HABITUATED TO STRONG PURGATIVES: Two rounded teaspoonfuls of Perdiem™ in the morning and evening may be required along with half the usual dose of the purgative being used. The purgative should be discontinued as soon as possible and the dosage of Perdiem™ granules reduced when and if bowel tone shows lessened laxative dependence.

FOR COLOSTOMY PATIENTS. To ensure formed stools, give one to two rounded teaspoonfuls of Perdiem™ in the evening with warm liquid.

DURING PREGNANCY. Give one to two rounded teaspoonfuls each evening.

FOR CLINICAL REGULATION: For patients confined to bed, for those of inactive habits, and in the presence of cardiovascular disease where straining must be avoided, one rounded teaspoonful of Perdiem™ taken once or twice daily will provide regular bowel habits. Take with a full glass of water or beverage.

FOR CHILDREN. From age 7—11 years, give one rounded teaspoonful one to two times daily. From age 12 and older, give adult dosage.

NOTE. It is extremely important that Perdiem™ should be taken with a plentiful supply of liquid.

HOW SUPPLIED. Granules, 100 gram (3.5 oz) and 250 gram (8.8 oz) canisters.

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ibuprofen

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double-blind, randomized clinical study of 287 patients.
trin was significantly more effective ($p < 0.01$) than codeine 60 mg at the
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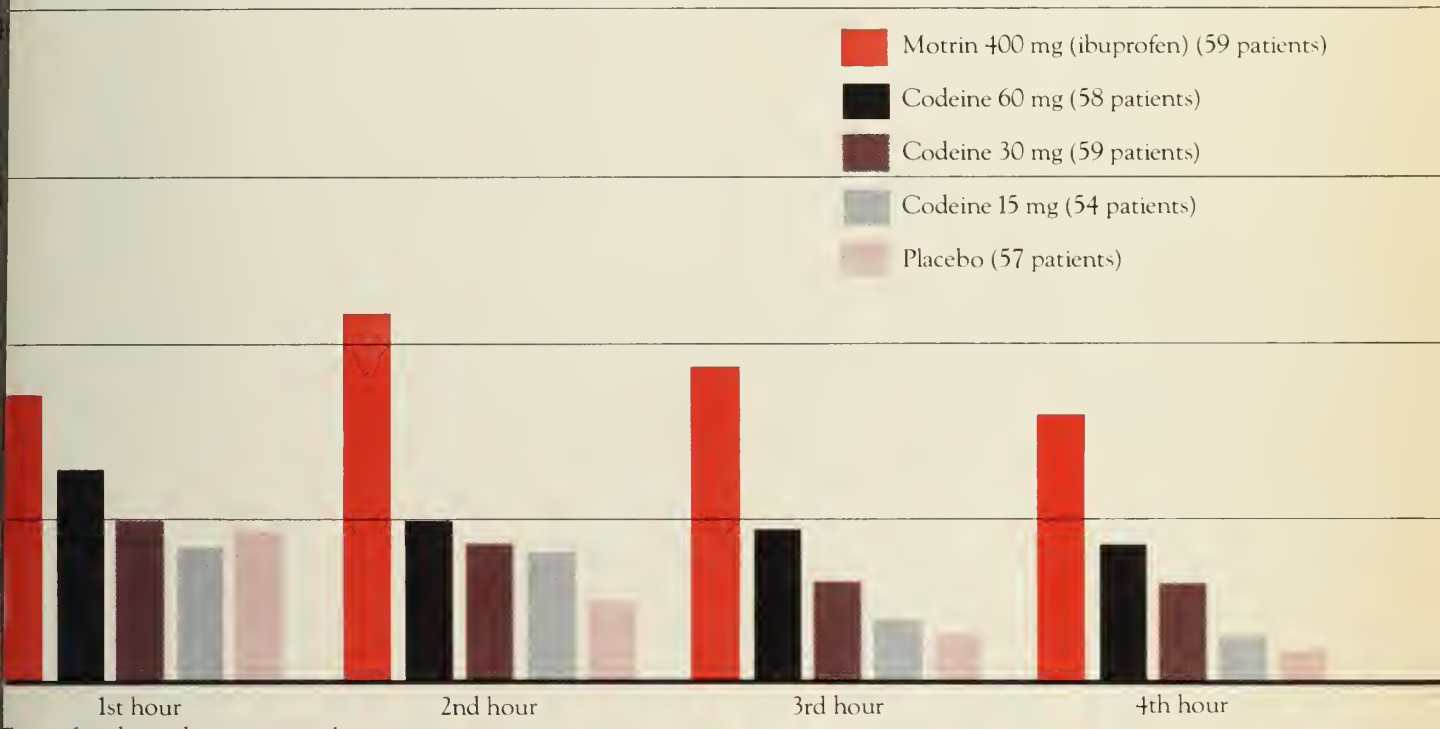
gree of pain relief—mean scores

Excellent relief 3 = Good relief 2 = Fair relief 1 = Poor relief 0 = No relief



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well-tolerated, nonnarcotic prescription for mild to moderate pain

Motrin® 400 mg TABLETS
buprofen, Upjohn

Not a narcotic • Not addictive • Not habit forming • Acts peripherally
Relieves pain rapidly • Indicated in acute and chronic pain • Well tolerated
The most common side effect with *Motrin* is mild gastrointestinal disturbance.

ease turn the page for a brief summary of prescribing information.

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Motrin® (ibuprofen)
now proved an effective analgesic for mild to moderate pain

Motrin® Tablets (ibuprofen, Upjohn)

Indications and Usage: Relief of mild to moderate pain.

Treatment of signs and symptoms of rheumatoid arthritis and osteoarthritis during acute flares and in long-term management. Safety and efficacy have not been established in Functional Class IV rheumatoid arthritis.

Contraindications: Individuals hypersensitive to it, or with the syndrome of nasal polyps, angioedema and bronchospastic reactivity to aspirin or other nonsteroidal anti-inflammatory agents (see WARNINGS).

Warnings: Anaphylactoid reactions have occurred in patients with aspirin hypersensitivity (see CONTRAINDICATIONS).

Peptic ulceration and gastrointestinal bleeding, sometimes severe, have been reported. Ulceration, perforation, and bleeding may end fatally. An association has not been established. Motrin should be given under close supervision to patients with a history of upper gastrointestinal tract disease, only after consulting ADVERSE REACTIONS.

In patients with active peptic ulcer and active rheumatoid arthritis, nonulcerogenic drugs, such as gold, should be tried. If Motrin must be given, the patient should be under close supervision for signs of ulcer perforation or gastrointestinal bleeding.

Precautions: Blurred and/or diminished vision, scotomata, and/or changes in color vision have been reported. If these develop, discontinue Motrin and the patient should have an ophthalmologic examination, including central visual fields.

Fluid retention and edema have been associated with Motrin; use with caution in patients with a history of cardiac decompensation.

Motrin can inhibit platelet aggregation and prolong bleeding time. Use with caution in persons with intrinsic coagulation defects and those on anticoagulant therapy.

Patients should report signs or symptoms of gastrointestinal ulceration or bleeding, blurred vision or other eye symptoms, skin rash, weight gain, or edema.

To avoid exacerbation of disease or adrenal insufficiency, patients on prolonged corticosteroid therapy should have therapy tapered slowly when Motrin is added.

Drug interactions. *Aspirin* used concomitantly may decrease Motrin blood levels. *Coumarin:* Bleeding has been reported in patients taking Motrin and coumarin.

Pregnancy and nursing mothers: Motrin should not be taken during pregnancy or by nursing mothers.

Adverse Reactions

Incidence greater than 1%

Gastrointestinal: The most frequent type of adverse reaction occurring with Motrin is gastrointestinal (4% to 16%). This includes nausea,* epigastric pain,* heartburn,* diarrhea, abdominal distress, nausea and vomiting, indigestion, constipation, abdominal cramps or pain, fullness of the GI tract (bloating and flatulence). **Central Nervous System:** Dizziness,* headache, nervousness. **Dermatologic:** Rash* (including maculopapular type), pruritus. **Special Senses:** Tinnitus. **Metabolic:** Decreased appetite, edema, fluid retention. Fluid retention generally responds promptly to drug discontinuation (see PRECAUTIONS).

*Incidence 3% to 9%.

Incidence less than 1 in 100

Gastrointestinal: Upper GI ulcer with bleeding and/or perforation, hemorrhage, melena. **Central Nervous System:** Depression, insomnia. **Dermatologic:** Vesiculobullous eruptions, urticaria, erythema multiforme. **Cardiovascular:** Congestive heart failure in patients with marginal cardiac function, elevated blood pressure. **Special Senses:** Amblyopia (see PRECAUTIONS). **Hematologic:** Leukopenia, decreased hemoglobin and hematocrit.

Causal relationship unknown

Gastrointestinal: Hepatitis, jaundice, abnormal liver function. **Central Nervous System:** Paresthesias, hallucinations, dream abnormalities. **Dermatologic:** Alopecia, Stevens-Johnson syndrome. **Special Senses:** Conjunctivitis, diplopia, optic neuritis. **Hematologic:** Hemolytic anemia, thrombocytopenia, granulocytopenia, bleeding episodes. **Allergic:** Fever, serum sickness, lupus erythematosus syndrome. **Endocrine:** Gynecomastia, hypoglycemia. **Cardiovascular:** Arrhythmias. **Renal:** Decreased creatinine clearance, polyuria, azotemia.

Overdosage: In cases of acute overdosage, the stomach should be emptied. The drug is acidic and excreted in the urine, so alkaline diuresis may be beneficial.

Dosage and Administration: Rheumatoid arthritis and osteoarthritis, including flares of chronic disease: Suggested dosage is 300, 400 or 600 mg t.i.d. or q.i.d.
Mild to moderate pain: 400 mg every 4 to 6 hours as necessary for relief of pain.

Do not exceed 2400 mg per day.

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May 1980

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- scored tablet for dosage flexibility

OPTIMINE®

azatadine maleate 1 mg tablets

CONTRAINDICATIONS Use in Newborn or Premature Infants. This drug should not be used in newborn or premature infants.

Use in Nursing Mothers. Because of the higher risk of antihistamines for infants generally and for newborns and prematures in particular, antihistamine therapy is contraindicated in nursing mothers.

Use in Lower Respiratory Disease. Antihistamines should NOT be used to treat lower respiratory tract symptoms including asthma.

Antihistamines are also contraindicated in the following conditions: hypersensitivity to azatadine maleate and other antihistamines of similar chemical structure; monoamine oxidase inhibitor therapy (See DRUG INTERACTIONS Section).

WARNINGS Antihistamines should be used with considerable caution in patients with narrow angle glaucoma, stenosing peptic ulcer, pyloroduodenal obstruction, symptomatic prostatic hypertrophy, bladder neck obstruction.

Use in Children. In infants and children especially, antihistamines in overdosage may cause hallucinations, convulsions, or death.

As in adults, antihistamines may diminish mental alertness in children. In the young child, particularly, they may produce excitation.

OPTIMINE TABLETS ARE NOT INTENDED FOR USE IN CHILDREN UNDER 12 YEARS OF AGE.

Use in Pregnancy. Experience with this drug in pregnant women is inadequate to determine whether there exists a potential for harm to the developing fetus.

Use with CNS Depressants. Azatadine maleate has additive effects with alcohol and other CNS depressants (hypnotics, sedatives, tranquilizers, etc.).

Use in Activities Requiring Mental Alertness. Patients should be warned about engaging in activities requiring mental alertness, such as driving a car or operating appliances, machinery, etc.

Use in the Elderly (approximately 60 years or older). Antihistamines are more likely to cause dizziness, sedation, and hypotension in elderly patients.

PRECAUTIONS Azatadine maleate has an atropine-like action and, therefore, should be used with caution in patients with a history of bronchial asthma, increased intraocular pressure, hyperthyroidism, cardiovascular disease, or hypertension.

DRUG INTERACTIONS MAO inhibitors prolong and intensify the anticholinergic (drying) effects of antihistamines.

ADVERSE REACTIONS The most frequent adverse reactions are underlined.

General Urticaria, drug rash, anaphylactic shock, photosensitivity, excessive perspiration, chills, dryness of mouth, nose, and throat.

Cardiovascular System Hypotension, headache, palpitations, tachycardia, extrasystoles.

Hematologic System Hemolytic anemia, thrombocytopenia, agranulocytosis.

Nervous System Sedation, sleepiness, dizziness, disturbed coordination, fatigue, confusion, restlessness, excitation, nervousness, tremor, irritability, insomnia, euphoria, paresthesias, blurred vision, diplopia, vertigo, tinnitus, acute labyrinthitis, hysteria, neuritis, convulsions.

Gastrointestinal System Epigastric distress, anorexia, nausea, vomiting, diarrhea, constipation.

Genitourinary System Urinary frequency, difficult urination, urinary retention, early menses.

Respiratory System Thickening of bronchial secretions, tightness of chest and wheezing, nasal stuffiness.

OVERDOSAGE Antihistamine overdosage reactions may vary from central nervous system depression to stimulation. Stimulation is particularly likely in children. Atropine-like signs and symptoms (dry mouth, fixed, dilated pupils, flushing, and gastrointestinal symptoms) may also occur.

If vomiting has not occurred spontaneously, the patient should be induced to vomit. This is best done by having him drink a glass of water or milk after which he should be made to gag. Precautions against aspiration must be taken, especially in infants and children.

If vomiting is unsuccessful, gastric lavage is indicated within three hours after ingestion and even later if large amounts of milk or cream were given beforehand. Isotonic and isotonic saline is the lavage solution of choice.

Saline cathartics such as milk of magnesia, draw water into the bowel by osmosis and therefore are valuable for their action in rapid dilution of bowel content.

Stimulants should not be used.

Vasopressors may be used to treat hypotension.

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The MD Class of 1980

Stanley M. Aronson, MD, Dean of Medicine, Brown University
Captions by Jeffrey Klopper, John Reasoner, and Janet Rubin

On the morning of June 2, 1980, sixty-one men and women will be awarded the degree of Doctor of Medicine by Brown University; this contingent of newly graduated physicians represents the sixth annual class since the medical school began in 1972. The faces, the perspectives, and the internship destinies of these graduates are proudly listed in the pages which follow.

The medical profession which these new graduates will shortly enter is presently confronting the reality that the most exciting new scientific disclosures will arise from insights and discoveries yet to be made, with meanings that we cannot possibly envisage today. These new physicians will join us to practice in an era where most anything imaginable seems possible and where the possibilities will indeed range well beyond that which we can possibly imagine today. In perilous times such as the years before us it will be hard to adhere to the classical precepts of the profession, to differentiate physics from metaphysics, to distinguish mad scientists from creative ones, to judge what has true possibility and what is sheer nonsense. There is a deeply intuitive and uneasy feeling in our profession that we are all on the threshold of a new era but that we are unable to identify with any semblance of accuracy the nature, the magnitude, or even the direction of these changes in the decades before us. It is so difficult separating graffiti from handwriting on the wall.

The faculty and the administration at Brown have a deep affection and regard for the current graduating class, and with considerable justification. They have endured these four difficult and rigorous years with an undiminished appetite for learning, a growing dignity, and an emerging responsibility for their new profession. Certainly there is something very serious and depressing when medical students such as these embark upon a career, rooting their learning in the shambles of human physiology, suffering, and tragedy. There is no other way to learn, and paradoxically this particular path yields for them a sense of human warmth and fulfillment and a firm alliance to their colleagues.

These new physicians are also learning the lesson that a physician is incomplete if he is but a therapist. The communication of ideas, instruction, and solace is central both to the scholarly and to the practical experience of medicine, and they therefore accept that they must also be educators to their colleagues, to themselves, and, most importantly, to their patients.

The new graduates have already encountered substantive changes in the nature of medicine which inevitably changes the ambience of their medical education. They have seen, for example, that practical applications of a rapidly advancing medical technology are resulting in the survival of large numbers of individuals who in prior centuries might otherwise have perished, therefore producing a population with measurable numbers of chronically impaired humans and thus increasing the relative importance of chronic disease as a responsibility of the profession. They have seen increasing availability of an amazing roster of profoundly effective pharmaceutical agents, leading to equally impressive numbers of iatrogenic disorders. They have seen access to tertiary medical care for a broadening range of our population, leading to immense costs to society and provoking debates concerning the limits both of these resources and of society's responsibilities in providing health care. And we in medical education have seen an increased concern and sensitivity by physicians and medical students to the quality of life and to the social impact of medical intervention.

The medical graduates of 1980 sense their own private transit as well as the metamorphosis of their new profession from priesthood to barber-surgeon, to scientist-clinician, and perhaps, shortly, to bioengineering. If this change be so, it will be their continuing responsibility to preserve the personal and intensely human quality of the physician-patient transaction and to resist firmly the temptation of allowing the profession to evolve only to a form of human engineering.

To our sixty-one new colleagues, I welcome them and wish them many decades of professional joy and fulfillment.

Alison Brent Anderson from Rye, New York spent her first two years at New York University School of Medicine. Business brought her husband to Providence and Alison to Brown. She is a true sportswoman. Alison will join the pediatrics staff at Rhode Island Hospital.

Julie Armada from Cranston, Rhode Island went to Clark University. She has been a runner consistently during her four years at Brown. Julie will do a year of surgery at Rhode Island Hospital before beginning an ENT residency at Yale University.

Susan Arnold from New York City and Italy went to Barnard College. We feel that she has retained her European sophistication. Susan will be beginning an OB/GYN residency at Mt. Sinai School of Medicine, Beth Israel Hospital in New York City.

Alida Aska from Lincoln, Rhode Island and Wheaton College received a Master's degree in Public Health at Harvard University. She has been active in all class political matters. Alida will be married to David Chen of the class of 1980 in June, and will begin a residency in medicine at Faulkner Hospital in Boston.

John Bergeron from Central Falls, Rhode Island and Brown has bicycled all over the United States, and he also likes to climb mountains. John will begin his residency in medicine at Rhode Island Hospital.

Michael Bookbinder from Downington, Pennsylvania majored in business at the University of Pennsylvania and gives valuable tax advice. Mike will begin a residency in pathology at Yale University.

David Brillon from North Providence, Rhode Island and Providence College collects everything. He is known for his nine-page histories and physicals. Dave will be a resident in medicine at the University of Rochester General Hospital.

Anthony Bruzzese from Providence, Rhode Island and Brown University knew how to read x-rays before matriculating in our medical school. He is editor of the yearbook and an Italiophile. Tony will begin his residency in medicine at Rhode Island Hospital.

David Chen of Providence, Rhode Island and Harvard College is one of the quieter members of the class. Rumored to be a violinist, he is known for his grey sweatshirt. David will marry Alida Aska of the class of 1980 and will begin a residency in medicine at Faulkner Hospital in Boston.

Suzanne Craig from Middletown, Rhode Island and Rochester, New York likes to swim. She will begin her pediatrics residency at Rhode Island Hospital.

Stephen Davis from Rumford, Rhode Island was a psychology major at Dartmouth College. Steve, an outdoorsman, built a house with some friends during medical school. He will begin a residency in family medicine at The Memorial Hospital in Pawtucket, Rhode Island.

Thomas DeNucci from Cranston, Rhode Island and the University of Rhode Island does photography and carpentry. Tom and his wife, Marie, will stay in Rhode Island while Tom begins his residency in medicine at Roger Williams General Hospital.

Steven Dorsky from Cranston, Rhode Island and Rutgers University, where he received a Master of Arts degree in physics, is famous for his dog Ari, who can spell twenty-two words, including "Doggie Dance". Steve, with his hospital administrator wife, Fran, and his accordion will go to New York City to begin a residency in orthopedic surgery at the Montefiore Hospital Center.

Candace Dyer from Warwick, Rhode Island and Duke University, where she earned a Master of Arts degree in pathology, worked on the admissions committee. Candy will begin a residency in surgery at Rhode Island Hospital, where her husband, Hugo Juerregi, is a pathologist and a Brown University instructor.

Keith Fishbein from Providence, Rhode Island and Brown is arguably the most argumentative member of our class. He commuted to medical school from Massachusetts, where his wife, Nancy, studied at the University of Massachusetts Medical School. Keith will begin a residency in medicine at the University of Pennsylvania, Graduate Hospital.

Kathryn Ford, the classic southern belle from Kingsville, Texas, came to Brown after two years at Texas Tech. Kathryn plans to begin a residency in psychiatry at Stanford University.

George Franco from Chepachet, Rhode Island and Boston College was a social worker in India before coming to Brown. He and his wife, Evvie, have two children. George will be remembered for his cynical sense of humor. He will begin a residency in pediatrics at the University of Rochester.

Charles Fredericks of Colorado Springs and Brown is our "all-American" boy. He has backpacked, fished and skied his way through Brown and will continue to do so as a resident in family medicine at Mercy Hospital in Colorado.

Charles Gaudet of Pawtucket, Rhode Island transferred to Brown last year. Charlie is a woodworker. He and his wife Cathryn, and daughter, Ellyn, are planning a short move to Boston, where he will do a residency in surgery a Boston University Hospital.

Carl Geyer from Middletown, Rhode Island and Johns Hopkins University is an outdoorsman and will be remembered as a trout fisherman. Carl will begin a residency in radiology at Walter Reed Medical Center.

Nancy Guggenheim from Teaneck, New Jersey and Brown is a flute and tennis player and loves cats. She will begin a residency in medicine at the William Shands Hospital of the University of Florida.

Quoc-Cuong Ha is from Vietnam and Amherst College. His only difficult subject in medical school was English. Quoc Cuong will begin his residency in surgery at the New York University Medical Center.

Carlene Hawksley from Seekonk, Massachusetts and Brown will be an army doc at Walter Reed Medical Center, in medicine.

Bruce Hookway from Littleton, Colorado and Wheaton College is a singer and pianist who also grows orchids. Bruce will begin a residency in medicine at Roger Williams General Hospital.

Shelley Kaplan of Newton, Massachusetts and Harvard University is a squash player and has spent much of her senior year in Boston. She will be married to Mitchel Driesman, class of 1977, and begin a residency in medicine at New York Medical College, Lenox Hill Hospital.

Ronald Kent from Setauket, New York and the University of Illinois came to Brown with a PhD in psychology. A coffee and sometime-Maalox addict, Ron loves tennis and sailing and hopes to pursue both while doing neurology at UCLA, preceded by a year of residency in medicine at the Pacific Medical Center.

Anita Kestin of Providence, Rhode Island and Princeton University carries a six-pack of V-8 juice and a squash racquet in her satchel. She can be found studying in Jake's ice cream parlor or travelling around the country courtesy of the American Medical Students Association. Anita will be doing a residency in medicine at Rhode Island Hospital.

Jeffrey Klopper from a farm in New Jersey and Yale University decided to become a psychiatrist at age 2. At Brown he was on the student council and admissions committee. Jeffrey is doing a year of residency in medicine before pursuing his career in psychiatry at the Yale-New Haven Medical Center.

Jay Krasner from Cranston, Rhode Island and MIT worked his way through Brown by being a garbageman in the early hours and playing in a band during the late hours. A marathon runner, Jay likes "action", and is going to begin his residency in medicine at the University of Pennsylvania Graduate Hospital, where he hopes to see a bit of it.

Setsuko Kuki from Chicago and Brown is our speediest medical student. She wants to be in the forefront of pelvic surgery and will do an OB/GYN residency at the Yale-New Haven Medical Center.

Robert Levin from Providence, Rhode Island and Tufts University has been known to take the most immaculate notes in the class. He will do a residency in medicine at the Newton-Wellesley Hospital in Boston.

Neil Lieblich from Lake Success, New York and MIT is the most famous magician in the history of Brown. He intends to cure sick children while pulling pennies our of their ears when he and his wife, Joyce, return to New York, where Neil will begin a residency in pediatrics at Cornell University, the New York Hospital.

Jacqueline Lyon of Providence, Rhode Island and Connecticut College will begin a residency in medicine at Danbury Hospital in Connecticut.

Louis Mariorenzi from Cranston, Rhode Island collects expensive cars. A full-time sportsman, Louis will begin to apply himself to medicine when he begins a residency in surgery at St. Luke's Hospital Center.

Charles Mock from East Greenwich, Rhode Island and Brown spent no more than $5.00 per week on food while studying medicine in Arkansas, Africa and Brazil. He travels light. Charlie will be a resident in family medicine at the University of South Dakota, University Hospital.

Kenneth Morrissey from Cranston, Rhode Island and Providence College plays squash, gardens and breeds fish. After being married in May, he will begin a residency in surgery at Rhode Island Hospital.

Mark Musen from Cranston, Rhode Island and Brown worked his way through medical school writing computer programs and stage productions. He plans to continue computer research while doing a residency in medicine at Stanford University Hospital.

Naomi Nomizu from Providence, Rhode Island and Yale University is our sweetest and most petite class member. She will begin a residency in medicine at the State University of New York, Kings County Medical Center.

Mark Nunlist of Chagrin Falls, Ohio and Brown was a submariner before bringing his family to Rhode Island. His wife woodworks and plays Parchesi with their children. Mark will be a resident in family medicine at Temple University, Lancaster General Hospital.

Wayne Ortiz from New York City and Brown University is both a weightlifter and fan of the arts. He will return to New York City to be a resident at City Hospital of Mt. Sinai School of Medicine.

Judith Owens from Providence, Rhode Island and Brown sings, draws and ice skates. She helped to found the annual medical school cabaret and has helped to organize commencement exercises. Judy will be a resident in pediatrics at the Children's Hospital of the University of Pennsylvania.

Kevin Petit of Greenville, Rhode Island and Brown was a founding member of Brown's cabaret as well as a singer, dancer and all that jazz. Kevin will intern in pediatrics in the Associated Hospitals Program of the University of Rochester.

Arnold Rabson from Bethseda, Maryland and Brown plays jazz saxophone. Interested in research in molecular biology, Arnold will begin by doing a residency in pathology at Peter Bent Brigham Hospital in Boston.

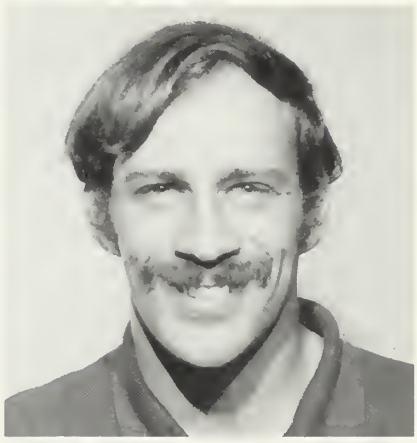
John Reasoner from New Haven, Connecticut and Boston, "better late than never", is an avid team sportsman and fan. He will take his wife, Laurie, and daughter, Alleeona, to Fort Belvoir, Virginia, where he will begin a residency in family practice.

Kathie Rones from Washington, DC and Brown roller skates, rides horses and plays racquet sports. She has been active in minority admissions. Kathie will begin a residency in medicine at Howard University, University Hospital.

Janet Rubin of Berkeley, California and Bryn Mawr College came to Brown to find herself and instead found Bill Cooper, class of 1978. "I like medicine, but I'm worried about my spirituality." Janet will begin a residency in medicine at McGaw Medical Center, Northwestern University, Chicago.

Loren Rubin of Northbridge, California and Stanford University came east to see the snow. One of five sisters, Loren managed to sew six wardrobes and bake tons of cookies during medical school. Loren will return to the sunbelt to do a residency in pediatrics at the University of California, San Diego, University Hospital.

Sue Schler of Satellite Beach, Florida and Brown does modern dance and arts and crafts. She will be a resident in medicine in the Associated Hospitals Program of the University of Rochester.



Carol Smith of Kingston, Rhode Island and Johns Hopkins University is interested in music, dance and adult psychiatry. After an internship at The Memorial Hospital, Pawtucket, Rhode Island Carol will do a residency in psychiatry at the Beth Israel Hospital.

J. Andy Solis from Jenkintown, Pennsylvania and Brown is the class political expert and newswatcher. He is going to the sunbelt to do a residency in medicine at the University of Texas, San Antonio Hospital.

Michael Stout of Middletown, Rhode Island and Boston College remodelled two houses with his wife, Polly, and their two daughters. He is an ex-science teacher and GI and will take his family to the Richland Memorial Hospital in South Carolina to do a residency in emergency medicine.

Christine Wellman from Geneva and Brown is one of the class artists and craftswomen. Christine will continue graduate studies after finishing medical school.

Deborah White of Cranston, Rhode Island and Brown is headed to Case-Western Reserve University with her husband, Timothy Young, of Providence. She will do a residency in pediatrics at the University Hospital while Tim pursues medicine at St. Luke's Hospital.

Timothy Young from Providence, Rhode Island will begin a residency in medicine at Case-Western Reserve University, St. Luke's Hospital.

Peter Yu, also called "Hey Yu", from Scarsdale, New York and Brown will do a residency in medicine at St. Luke's Hospital Center, Columbia University in New York City.

August Zabbo from Warwick, Rhode Island and the University of Rhode Island will take his family to Wright Patterson Air Force Hospital, where he will do a residency in surgery.

Franklin Zimmerman from Beachwood, Ohio and Brown came to medical school after much deliberation. "I wanna be a star," he confides. He sings, plays guitar and piano. Buddy will marry Laura Grant (Brown, class of 1976 and Columbia University MBA, class of 1979) and do a residency in medicine at St. Luke's Hospital Center, Columbia University in New York City.

Also:

Seth Izenberg from Metuchen, New Jersey will begin a residency in surgery at Rhode Island Hospital.

Linda Liu from Belgium and Wellesley College is our world traveller. She will do a residency in medicine at Hahnemann Medical College Hospital in Pennsylvania.

Karen McGoldrick from Warwick, Rhode Island and Providence College began medical school as one of the quietest members of our class. Now more assertive, Karen will begin a residency in OB/GYN at Women and Infants Hospital in Providence.

Vona Wright from Nashville, Tennessee and Brown runs, dances and maintains a sunny disposition. She will be a resident in OB/GYN at Boston City Hospital. ■

Notes from the Class of 1980

Eight Students Talk About Medical School and Medicine

I. The Responsibility to Ourselves

Jeffrey Klopper

The most important role of a graduation is as a pause; to look back, then ahead, gather perspective, hopefully some insight, and prepare to move on.

The role of a physician, our role, is one which we have long begun to assume. For it we have worked very hard, constantly having to compete with others and to struggle in overcoming many hurdles. We have had to put much off for the future, many of us having in a very real sense delayed beginning to enjoy our lives or even to establish ourselves as individuals.

We have had much to learn: an enormous body of knowledge; how to use all of this information; what to use when it is inadequate or conflicting; and how to keep up as it constantly grows and changes.

We have mastered many skills and have learned how to take responsibility and how to think.

There are many wonderful things which we can do. We can ease suffering and sometimes cure disease.

Many of our lessons have been difficult ones to learn: that we often must hurt to heal, that our patients sometimes die, and that it is not easy to be precise scientists and caring human beings simultaneously.

In the future, much will be expected of us by ourselves and others. We shall always be learning, examined, scrutinized, criticized. We shall always be expected to cure; to be all knowing, always available, always right; and never to err. Always to give, to be all giving, all caring, never to take, always to be self-sacrificing. Our smallest error will be called negligence and the least weakness incompetence. The most exacting science and the most compassionate humanism will be expected.

No other group will work as hard, or as long, or bear as great a responsibility as we shall. We shall deal with suffering, death, dying, and often defeat. We must treat equally those patients who will not comply with treatment, or may be angry or quite unlikable. We shall be compelled to learn legal medicine and at times to practice defensive medicine.

We shall have more than our share of impossible moments filled with our own impossible emotions: frustration, anger, despair.

We would not have worked so hard to become physicians if there were no rewards in medicine. We will gain respect and be well paid. There will be many moments of excitement, pride, challenge, and joy. We have chosen a most demanding profession, but an extremely rewarding one.

Graduation is a time to gather thoughts into perspective and gain as much of a working philosophy as we can before we set out. Many of the principles which will be important to us are either self-evident or have been well emphasized lessons of the past four years.

We would not have reached this point alone, without our family, friends, and teachers. We have been entrusted by society with a great privilege and honor. Much has been given to us, and much should be expected from us. We do have a very serious responsibility to work hard, and to

maintain our skills and knowledge and the highest ethical standards.

Some of the most important lessons, however, are not emphasized. We have an obligation to ourselves. We should take pride in the responsibility which we have undertaken and the skills we have mastered, respecting ourselves for what we have done and more so for what we must do in the future.

While accepting the demands and responsibilities of our profession we should not in undue modesty shy away from its privileges and rewards, and our roles as leaders. We must not overlook the fact that we are after all people — with special knowledge and skills — but with very human feelings and needs. We tire, become troubled, and sometimes ill. We have families, friends, and interests outside of medicine. We must acknowledge our personal feelings, gratify our own goals, and fulfill our own selves.

Medicine must not always be first, and we need not feel guilt when it is not. Only by not letting medicine consume us can we be the best physicians we are capable of becoming and deliver the best possible medical care.

II. I Remember When

Neil Lieblich

At graduation time the air is filled with profound quotes — words that hail the virtues of knowledge and judgement. The speeches all look to the future with a bright idealism quite unique to the academic world on its day of laurels.

It's hard to say what the future holds for us. Others have given us their thoughts on the subject. They usually begin by saying, "I remember when I was an intern . . ." What follows this, are often unbelievable accounts of hospital training years ago.

However, I am more in the position to speak of the past four years, because I remember when I was a medical student.

The first year is somewhat of a blur. I remember the anatomical tales of the Irish Giant and of the great masters of dissection. We were taught biochemistry and physiology; pharmacology and pathology. From talks on the incest taboo to the labs of microbiology, we seemed to muddle through. Then one day, at the end of the year, we bought our doctors' bags and instruments to fill them. There was great anticipation in our second year. I remember all the warnings about IMS or "Integrated Medical Science", the name for the second year. Much of what was said was true. It was a long year that moved at a fast pace. There were staggered courses with final exams every few weeks, all cramped into a small cellar room without a window to spare. We also started physical diagnosis. This was our introduction to the secrets behind the physical exam. No longer would a physical be looking, listening, tapping, and poking. Now it was inspection, auscultation, percussion, and palpation.

By the end of IMS, our class looked rather shell-shocked, but it was finally over. Now, it was time to start our clinical years. It became all too clear that the diseases we had learned about were attached to real people with families, expectations, and fears. The excitement about making a diagnosis had to be tempered with the understanding of its consequences to the patient. From medicine to surgery; pediatrics to obstetrics; community health to psychiatry. We ran from the Miriam Hospital to Roger Williams, to Butler, to Women & Infants, to Rhode Island Hospital. Each hospital had a flavor all its own.

There were sad times and happy times. Cancers spread too far, and cancers permanently in remission. Fatal strokes that ended lives and CPR (cardiopulmonary resuscitation) that saved lives. The death of a baby born too young to survive, and the birth of a healthy baby photographed by the father.

Throughout the year our experiences increased and, we hoped, our judgement as well.

Our last year at Brown was filled with electives. These were times to round out our education in specific fields. We were subinterns, consultants, radiologists, pathologists, and private practitioners, but only for a month at a time. The

fourth year was also the time for traveling and interviewing. All of this to seek positions in hospitals for the next step in our training. It was a long wait, but finally came "match day." With our hospital assignments secured, we waited for today.

Medical school was at times pure enjoyment and at times a sheer ordeal. But, as of today, we shall all be called physicians. The responsibility to care for all those who seek our help will be ours. We've had the strength to endure. Now we have the honor of becoming part of a most honored profession.

III. On Graduating

Mark Musen

Monday, June 2 will mark an important transition for the class of 1980. We shall don our heavy academic robes with green hoods, solemnly accede to the Hippocratic oath, and then march to the college green to accept our diplomas — a "receipt", as it were, for four years of education and devotion to Medicine. Graduation will signify that we have obtained a fundamental amount of knowledge and skill. It will signify that, in a medical sense, we are at last fully responsible for our actions. For many of us, it will mean the start of our first (decent) paying job.

The seemingly miraculous transition of ordinary mortals into competent physicians has been popularized in American literature from *Arrowsmith* to *The Making of a Surgeon,* even to *The House of God* — books that have underscored what those of us graduating on Monday already know: that medical education is a gradual, tedious process with few of those moments of sudden accomplishment that many of our friends are convinced must occur; no one takes out an appendix the first day of his surgical clerkship.

This is not to say that medical school does not entail a series of turning points. Indeed, our past four years at Brown have been punctuated by a number of small but significant "rites of passage". In my mind, the robes and the procession and the band on graduation morning will not be there to honor the acquisition of our MD degrees. Rather, graduation will be a celebration of those many small but important transitions we all experienced as medical students — key transformations we hardly noticed at the time.

The first rite of passage was Anatomy. Like generations of students before us, our entrance into the dissecting room was marked by a sense of the forbidden and a feeling of unreality. The cadaver was our first patient and our first contact with the inner manifestations of disease. It was in that cavernous chamber, with glaring overhead lights shining on a matrix of motionless bodies, that death took on a new meaning. It was there we learned that Nature could be so repeatable, as we marveled how thousands of structural relationships were miraculously reproduced with only minor variation in each of us — phenomenal consistency ensured by only a smidgeon of DNA. And, as we lifted each part from its fascial bed, it was difficult not to think of Vesalius or Galen, who hundreds of years earlier had performed the same dissection. Every cubic millimeter or our cadaver had already been mapped out by the great anatomists before us. Nowhere else in medical school would knowledge be presented with such certainty.

There were other transitions during the first year. We had a course in Pathology, our first formal introduction to disease. The semester was marked by both hundreds of microscope slides and an endless parade of inflamed, degenerating, or cancerous human organs, which all of us looked at and some of us would touch. In Anatomy, the body had seemed perfect. Now it was clear that things could go wrong.

By the second year of medical school, we were learning how to "lay on the hands". We would examine a different patient each week at least once — often we would go back, suddenly realizing we had not felt for the thyroid or had forgotten to listen to the lungs. We learned to interact with other people in a professional sense and to cope with different situations. I don't know how many different patients that year asked me "Are you sure you're old enough to be doing this?"

A most important rite of passage occurred for me, at least, in the winter of the second year. While taking the blood pressure of my patient for

the week and assuring her that, yes, I was old enough, a nurse came by and asked me simply to record my reading on the bedside chart. I was stunned. I was ecstatic. At last, I had something to contribute.

The start of our clinical clerkships then signaled an abrupt turning point. Our class would no longer be together as a unit. We would no longer get up in the morning and go to school; we would go to work. Suddenly, we had to dress respectably.

There was the first time we had to draw blood. The first IV (intravenous). The first blood gas. And of course, the first time we heard our names being paged.

We each attended our first operation, delivered our first baby, and made our first independent diagnosis.

We each discovered that there was a whole host of new problems to be tackled, problems for which we were frightfully ill-prepared. For example, there was "constipation". (Basic Medical Science had taught us nothing of the advantages of a soap suds enema over milk of magnesia.) There was "heartburn". ("What do you mean ROLAIDS isn't in the formulary?") There were CRANKY KIDS AND CRANKIER MOTHERS. Confused men who could pull their Foley catheters from their bladders. Agitated women who, even though restrained, could bite off their IVs. Destructive patients and seductive patients. All of them had to be dealt with.

We also had to deal with their families.

And, after four years, we are finally ready to graduate. While patients may have called us "doctor" for some time, we now no longer feel that we're just slightly deceptive in acknowledging the title. In society's eye, the MD degree implies that we have attained the level of knowledge necessary to make medical decisions. What is more important to us, however, is that we have now reached the level of understanding that allows us to appreciate what it is we *don't* know.

We will all continue to grow within our chosen medical specialties, becoming increasingly capable as our skills and expertise mature. Yet as we develop as physicians, we shall merely be expanding the basic groundwork that has already been laid here at Brown. This is true because our most important rites of passage have been *attitudinal*, with each new situation refining our appreciation of medicine and our approach to caring for other people. We shall be accepting our diplomas next Monday not so much in celebration of what we have just accomplished, but rather to affirm that we have at last reached that major turning point in our lives and that now allows us to become the best kind of doctor we know how.

IV. Our Own Lives

Kevin Petit

Medicine, we are told, is a demanding mistress; demanding of our time and our talents, and much of our energies. As we pause on the brink of careers we have long awaited, there is a mingling of pride and adventure, and just a touch of anxiety at the long days and nights to come that well attests to the truth of this metaphor. And at least in part, this anxiety stems from the unvoiced question — where will the demands end?

We have all met people who are so involved in their work that, were you to ask them who they are, they would identify themselves with what they do: "I am an accountant", "I am a lawyer". And now we are perhaps more prone to this than many for today our work literally becomes part of our name. Yet are we any different than we were yesterday? Simply because we now affix a title to our names, are those names any more worthy than they had been?

True, we are not quite the same people who first gathered that fine autumn morning four years ago; we are older, for certain; a bit more learned, perhaps, and we hope a good deal wiser. That we have changed as change should be, the change of growth, of broadening, or has it been the change of shedding, forsaking much of who we were for the trappings of an image we wished to emulate?

For each of us the answer may be different. For all of us there may at least be the fear that we have already lost a part of our "self", compromised it somehow in this barter of time and energy, this struggle to become bright and shining new doctors.

It is not an irretrievable loss, at least not yet. The "selves" are still within us, buried beneath much trivia perhaps, but there nonetheless, waiting to be retrieved, if we have the will.

Henry David Thoreau once wrote: "The mass of men lead lives of quiet desperation. What is called resignation is confirmed desperation. But it is a characteristic of wisdom not to do desperate things."

These next few years may well be the most challenging for us, and also the most desperate. As the demands of this mistress become ever greater, we must somehow strike a balance between the physician and the person. As our time becomes largely not our own, it will be important to keep in mind the necessity of taking some moments to be alone, to forget the cares and demands of others and retrieve one's self, to listen to the heart and heed what it has to tell us.

The tides of medical knowledge will shift. Today's dogma may well be tomorrow's heresy. Therapeutic panaceas will come and go, but you will still be you and I shall always be myself, and this, too, must be our concern.

What I advocate is no "easy-way-out". Good doctors are not lazy, and there is no substitute for dedication. Rather I would that we might give of our whole hearts and minds to our work, devote our full energy to what we believe in, but save just a piece of our souls for ourselves, so that, as Thoreau put it, when we come to die we may not discover that we had not lived.

V. The Importance of the Physician as a Role Model

John Reasoner

When the graduating medical student contemplates his/her future and decides what his personal role in society should be, he must also take into consideration what his public and medical colleagues expect. Through the years his title as physician has meant many things to many people. To his patients, he is a healer; to his community, he is a leader; to his neighbors, he is a friend; to his family, he is a husband, father, and provider. For those who will enter the field of academic medicine, in whatever capacity, the physician is also a role model to his students.

During their clinical training medical students work closely with the physician and are usually very impressionable at this stage. With the bulk of learning via lecture behind them, the students now acquire knowledge through experience, observation, and mimicry. In this situation the physician will find himself the object of examination and should be cognizant of the impact his actions will have on the future physicians.

In becoming a physician each student undergoes some process of socialization[1]. He internalizes medical attitudes and values which will guide his professional development. During his frequent rotations through various specialties, he has the opportunity to be exposed to the many roles lived out by the physicians with whom he works. Recognizing that many of these roles have merit and value in certain clinical settings, the student emulates the "good traits", while rejecting those which he may perceive as undesirable. The end stage of this process in medical education is the development to medical maturity. This final stage may be what Pellegrino calls the Compleat Physician[2] — an educated man, a competent practitioner, a compassionate physician. Or, it may comprise the more than eighteen characteristics stated by Rakel[3] to be desirable for all physicians. In any case the medical student ideally seeks the clinicians who "have it all together", from whom they may learn and by whom they may set their standards.

The one-hundred-pound-overweight physician explaining the importance of dieting will not have a great effect on his patients or the student observing him. The same follows for the cigarette-puffing doctor who discusses with the student the serious outcome of pulmonary carcinoma or chronic obstructive lung disease. Today's push for preventive medicine calls for its practitioners to set forth a good example, not to practice hypocrisy. The physician who maintains good health and emotional well-being exerts a positive influence on those involved with him.

If the physician's relationship with his patient is authentic and has meaning, if he reenforces the therapeutic intent, and if he demonstrates a basic

respect for the worth and dignity of each patient, the student will demonstrate development along similar values. Conversely, if the discontented physician shows callousness toward the patient and downgrades the concern of the encounter, a lack of humanitarianism may be fostered in the student he instructs.

An attitude of detached concern may be part of the maturation and socialization of the physician, for it is so frequently encountered. Nonetheless it should not cloud the physician's ability to relate effectively to his patients. Medicine makes demand on time, energy, intellect, interest, and emotion. The physician must make life and death decisions on the basis of inadequate or conflicting data. The reduction of this daily stress requires the development of an attitude of detached concern. This development allows the physician to make objective decisions in the patient's best interest without interference from the physician's concern for the patient. However, inappropriate detachment may be viewed as lack of concern by the student for the patient rather than objectivity. The physician-instructor should make this point clear to those attempting to learn the practice of quality clinical medicine in order to avoid any misconceptions.

The student-physician relationship is another important aspect of clinical instruction which must be understood by the physician. He should recognize the needs, concerns, and anxieties of the student who has been asked to function as a doctor without being one. He should foster a feeling of self-worth in the student, who may then find it easier to interact with patients in a similar manner. If, on the other hand, the role model is a negative one, relating to his students with sarcasm, humiliation, excessive stress, and downgrading self-esteem, then these attitudes are transmitted in the development of the student's medical identities as well as the patients they care for. Hence, an attitude of basic respect for the students' needs helps to develop an overall learning experience that promotes good treatment.

In summary, a one-to-one relationship between a physician and student has a major influence on the student's thinking. Honesty and genuine concern for patients strengthen the student's emotional and educational development. The physician who trains medical students must realize the impact their lives have on their pupils. Setting an example as a role model has far-reaching positive and negative influences.

References

[1]Levinson DJ: Medical education and the theory of adult socialization. J Health Soc Behav 8:253-265, Dec 67.

[2]Pellegrino ED: Educating the humanist physician. An ancient ideal reconsidered. JAMA 227:1288-1294, 18 Mar 74.

[3]Rakel RE: Family physician, in Rakel RE, Conn HF (eds): Family Practice. Philadelphia, WB Saunders, 1978.

VI. Brown Years

Janet Rubin

The great day arrived: anatomy, our first real medical school course, was beginning, and we were ready. Perched in a medieval wooden amphitheatre (thoughtfully designed so that to sleep was not to dream but to plunge into the pit below), we peered down at the dissecting table. Certainly our careers in medicine had begun! The professor wheeled in the draped figure — would he whip off the sheet, fulfilling our most horrible expectations? Would the corpse of our barely initiated careers lie naked before us? Delicately the professor unveiled but the shoulder — the back shoulder. Relieved, this first major hurdle overcome, we buckled down to the business of learning medicine.

Nearly four years later the class of 1980 will spew forth from the warm sands of the Ocean State, seeding the hospitals of America. Yet the memory of those hard wooden anatomy seats cuts into us as if we sat there yesterday.

Our first year we had minimal contact with living subjects: we practiced on ourselves and on man's best friend. We traced each other's EKGs, and, with trepidation, drew each other's blood. We collected urine and measured pressures after running up and down stairs. Human experimentation gave way to the dogs; various sleepy, anxious, adoring canines were subjected to pharmacologic and physiologic insult. We longed to leave these furry creatures and again practice our knowledge on our own species.

By the end of the first year we had acclimatized to being medical students. The thrill of receiving

unsolicited mail addressed to Doctor and carrying anatomy texts that proclaimed loudly our exalted status had faded. We had before us the grinding curriculum of the second year — the so called "Integrated Medical Science" (IMS), a full-time occupation.

A basis in pathophysiology is a prerequisite to the laying on of hands. From this postulate was IMS born, and for three hours each morning and more hours in the afternoon we slumbered away in a windowless classroom. We became indistinct, without individuality, sixty-odd students in the dark squinting at the glare of endless slides. We became distant from each other, falling into the cruel routine. We separated like layers of jello and whipped cream: the back-row caste, the front-row caste, and the middle-rowers now filled the ranks of a previously classless society. And the untouchables, lost seed who drifted from front to back without ever finding their proper place, lent an air of unrest to the stuffy climate. The front-rowers listened intently, coffee in hand. The middle-rowers took notes critically, coffee and donut next to pen. The back rowers — occasional listeners, occasional sleepers — watched as the drifters drifted (occasionally intent, frequently critical, and often asleep).

We didn't go entirely in silence through those dark hours. Oh, no! Notes, chortles, and the best laid plans rumbled through the hours of clinical pathology, pharmacology, infectioncardiologrenal-patho . . . Overtime lecturers were confronted by a dandy bird smoking a cigar, lowered craftily from the pipes above on a pulley operated from the back of the room. "We need a break!" implied the bird — and break we did — flowing out, gaining color, from IMS into the sweet light of day.

The grimness of the IMS classroom drove us to expand our outside interests. No longer was our passion intended for medicine alone as we dispersed. Some played squash; some rehearsed for piano concerts and cabaret routines. Others buried themselves in romance, others in science fiction. Our hours outside the classroom were succor with which we nursed ourselves through the second year.

By third year we'd changed physically as well as emotionally and intellectually. The quantity of weight lost and gained in the last years was astonishing. Some had gone up, some had gone down, and some up and down or down and up. Most likely, we rationalized. It all equalled out, as if only a certain mass was fated for our class — no more, no less. Children were born, marriages planned, and houses built, bought, and sold. Running hit the national scene, and hit the class of '80; running down the boulevard, we laughed at each other and at the many pudgy, panting doctors we easily passed. (Two years later the same doctors, slimmer and swifter, laugh as they pass us, and we no sloths be!)

The best part of the third year was that, eager doctors all, we went to the hospital, leaving the classroom behind. Daytime, nighttime, we went, talking to and caring for patients. During 6 AM surgery rounds we trailed after the team seeing sixty patients in as many minutes. We learned to be succinct: "Move your bowels, pass any gas?" In the OR we learned humility, our retractors pulled back reverently as we watched the ever obstructed field. At the same time we desperately tried to anticipate the next terrifying surgical question: Was it up, down, left, right, medial, or not there at all? The rigors of surgery fast sliced the week away — you liked it or you didn't. (One of us liked surgery so much he had his appendix out!)

In obstetrics and gynecology we were allowed to stitch incisions closed and tie surgeon's knots. We delivered babies and felt contractions (was that one? — it was subtle), we inserted IUDs and passed out birth control pills. (The appendectomized student, never outdone, had his first child delivered while he was on the OB service.) We followed neonates into Pediatrics, learning to explain complex issues to children while watching their reflection of the adult world of the hospital.

The amount of knowledge necessary to get through three months of a medical clerkship seemed insurmountable to us. But by dogging our interns and following our patients — typical COPDers, out-of-control diabetics, ROMIs, arthritics — we managed (although we still wonder whether normal sinus rhythm in Rhode Island is atrial fibrillation). This was medicine, and we were its ardent disciples! We would increase health and promote Good with our armamentarium of drugs and tests; and with this faith we applied ourselves ever more astutely to the business of listening to chests, analyzing lab results, and keeping up with the journals.

Psychiatry opened our eyes. We were awkward, seeing each other with our new insight. Our patients were manic and schizophrenic and had impaired reality testing: yet was our own reality the golden measure of normalcy?

While busy in the hospitals, third year passed and fourth year loomed sweetly on the horizon. We made plans, some to go into medicine, some into surgery, or OB/GYN, or pediatrics and other branches. Investigating residency possibilities, we fanned out of Providence toward bigger cities,

warmer climes, family and friends. The first semester was packed with interviews and how well we all learned the chorus of the residency interview: "Where are we from: Do we like Brown? Why are we interested in medicine, or surgery, or pediatrics? What is our class rank?" Suddenly the chorus ended and we had to make our hospital choices. The match was sealed. Fourth year stretched out unencumbered by anxieties of "doing well"; we were able to enjoy the hospital and the profession, finally, without the fear of constantly being judged.

While waiting to graduate we examine our progress and experiences in medicine. The wholesome enthusiasm of the third-year medical clerk giving steroids to his patient for her possibly steroid responsive disorder is breaking down. There is a new skepticism. Are we doing something Good for our patients — our terribly ill patients — by drawing their blood, administering to them potentially lethal drugs, keeping them away from home in the confusing hospital routine? Will the old, the demented, the chronically disabled thank us for having their lytes corrected, their hemorrhages dammed, their fluids diuresed from swollen limbs? Are we prolonging their lives or just protracting their misery? Are we curing their acute problems or confusing their constitutions with iatrogenic illness? We are unsure whether we can safely ask these questions, for shortly we shall be accepted warmly into this profession we have labored so long to join. Once members, our questions regarding issues in medicine become challenges to ourselves and our chosen reality.

The next forty years are for shaping our profession and our lives, and meeting the challenge of questions we learned to ask in medical school. Our careers in medicine, begun with the unveiling of a shoulder, are now in our own hands. Our memories, our growing knowledge and our perplexing questions are rich reminders to the class of 1980 — that we must continue to search and change — and always seek to be the best physicians possible.

VII. We the Students

Peter Yu

Seven years ago, when I first arrived at Brown, the medical school existed in many ways more in the minds and far-reaching vision of its founders then in actuality. During those seven years, however, it has grown, unfolded, and expanded. Today, as a new decade begins, the school is firmly entrenched in the medical community, as well as the very life system of the State of Rhode Island and, by its presence, has added greatly to the quality and meaning of that life. This achievement is a reflection of the dedicated work and enthusiasm of many people. Brown students have had no paucity of outstanding physicians as role models. It is because of these physicians that the medical school exists today to serve the people of Rhode Island. Nevertheless, the school was created primarily as an environment in which future physicians could explore and attempt to understand their chosen field. Separate from the physical structure, which even today remains bereft of name and front entrance, are the medical students who are in fact the medical school. Truly, the medical school exists because of the students that comprise it; they are its reason for being. And this is what commencement is all about. It is a celebration of the medical students who graduate, and through them of the school itself.

During these spring months, in 125 medical schools across the nation, over 10,000 students will gather to mark the completion of four difficult years. And, although unanticipated difficulties lie ahead, commencement holds a special meaning, a day when one at last can say, "I am a physician." That statement, which we shall now share in common with all physicians, serves to join us fully with the medical community. Yet, I feel that there is something different and special about this graduation, that even as it links us with so much, at the same time it sets us apart as unique in place and time.

We are still an institution in its infancy, with fresh traditions and few memories. Our existence is in the present and the future, not in the past. However, while the future may hold all the more promise because of this, the present has been correspondingly more difficult. The creation of a medical school is certainly an ambitious project. Often we students have been as pioneers venturing

into unknown and sometimes hostile territory. In my time here, I have seen the medical school curriculum, the basis of my education, progress, regress, and at times just stagnate. Furthermore, there have been few generations of preceding medical students to have clarified the role of the student, or to have established the relationship between students and those who are in a position to teach. The most difficult, but nevertheless the most valuable tradition for a new school to establish, is an unwaivering commitment to medical education. As with all traditions at Brown, this one is as yet young and fragile. Consequently, there have been times when my education became a vague and nebulous entity. At times I have felt like a visiting guest, and my education seemed to consist of a great walking tour of hospitals, offices, and clinics in the state. And, at other moments, I sensed outright hostility, as if I were an intruder who had inadvertently walked into an awkward family situation. Such experiences are unavoidable as the school strives to reach out into the existing medical establishment and join with it. Our education has been an integral part of that process, a process that has been largely successful to date. But if our task has been made more difficult, and if we have been challenged to work harder to obtain our goals, then the final achievement has become so much more our own. What we have accomplished in our years here, and what we recognize today as fact can have perhaps more meaning to us at Brown than it might have at other more established institutions. This is then a uniqueness in place.

Earlier I said that we have no past. Our presence today gives testimony to the viability of Brown's present. It is on the basis of that viability that we have the basis for hoping for the future. Nevertheless, there is as yet no clear indication of the place that Brown will occupy in the national medical community — we are still too young. Too many questions remain unanswered concerning the future direction of the school. However, as we look to the future, two things seem clear as we attempt to chart the future growth of the school. The first is that the reputation of the school will largely be set within the next ten to fifteen years. The second is that the reputation that Brown earns and deserves will be based upon the quality of the physicians it creates. Those who encounter us will see Brown through us. Because an institution's reputation, once established, is so difficult to change, the first few classes to graduate will have an opportunity to help determine the future direction of the school in a manner few other classes will have. And so, an uniqueness in time.

This may all seem like quite a burden to carry, especially after the proverbial 36 hours on call. It need not be. What is required is that we strive to accomplish the best that we are capable of, in whatever area we choose to do so. The energy and flexibility of youth that exists at Brown has allowed us to pursue whatever brand of medicine interested us, from academic research to family practice and primary care. The last twelve months of our formal medical education bear witness to the freedom we have had in molding our educational experience to fit our own personal concepts. This represents an aspect of medical education that I should not care to lose. Brown need not be known for producing any given type of physician, rather it should be known for producing the best physicians in whatever field they choose. If Brown achieves recognition for that, it will have an endowment that few institutions, in place or time, can have matched.

VIII. The Party's Over

Franklin Zimmerman

Graduation is a unique phenomenon. It is both a celebration and a tribute, a beginning, and an epitaph. It is a time when we sadly bid farewell to old friends, and await the making of new ones. The confidence gained by past experience is tempered by the anxious prospect of new challenges. Indeed, it is a time replete with adulation and self importance, but there are limits to be set.

Four years ago, when we began our studies in medicine, it was the time of the American Bicentennial, a time when this country was filled with a greater frenzy of self praise than any other time in recent history. Somehow that paper patriotism was fun while it lasted, but for Old Glory and indeed, for us, the party's over. After the last firework dimmed and the final "tall ship" sailed out to sea,

this country was still left with the same problems; and, after the last glass is toasted to the new physicians, we shall still be faced with the most difficult challenge of our careers — our internship.

I can think of few words in the medical student's lexicon which command such a dual love-hate relationship as internship. Some of us may have a vision of ourselves as the modern legionnaire, clad in white and perhaps more reminiscent of the "man from Glad" than an avenging angel. Others see a more gloomy future with a perennial cloud above us like Joe Btzflk of Li'l Abner fame. Regardless of our individual outlook, to be sure it will be the best of times and the worst of times. We shall be able proudly to claim our victories, and shuffle apologetically from our mistakes without hiding behind the phrase, "Well, I'm only a medical student." From this day forward, we append the title of doctor, with all its rights, privileges, and responsibilities.

Despite all of the speculation on the subject, no one can truly understand what an intern goes through except another intern. The trials involved are certain; so when some unrecognizable creature out of a late night movie returns home to family and friends after a night on call, try to find a last vestige of compassion to add to the other sacrifices we have asked of you. Now, at this moment some of our mentors may be thinking, "Quit griping. I went through it, and in the old days, we were lucky to take home forty dollars a week". I have no dispute with this, and clearly our venerable predecessors endured much to achieve their level of competence. We should consider it an honor to be their equals. However, in many ways, they are not our equals.

There is a familiar anecdote of the young boy who says to his parents, "History class was so much easier for you; there was so much less to learn then". That apparent naivete has relevance today. It has been estimated that the amount of medical knowledge doubles every ten years, and to those of us without years of experience the task seems overwhelming. The new physician is asked to be familiar with routine measures of life support that would have seemed extraordinary ten years ago. We must be current with the medical literature and therapeutics, and somehow learn to deal with the multitudinous sea incarnadine of red tape that exists in our medical system. Oh to return to the good old days, when all you had to do was dance a little jig and select the proper leech; but leeches have not as yet been approved by the Food and Drug Administration. So we are left in our current predicament. The result has been that, in our frenzy to master our craft, patients are all too often reduced to cases. Someone's loved one becomes just another number. It is important that we all step back for a moment to remember just whom we are trying to help. I also hope that this reflection may bear results in the face of an ever-increasing public demand for medical proficiency.

The purpose of this occasion is not to belittle our training. Rather, it is a means to add to the other memories we have come to cherish. Picture the first day of anatomy. Sixty near strangers gather in a room, all filled with the same strange fascination and yet apprehension as the cadaver is wheeled in. There is the memory of delivering your first baby, and being scared half to death that you would drop the slippery squirming thing. I can remember the kind old encouraging obstetrician telling me not to worry about dropping the child, for, if I did, I would be killed. There was the joy of discharging a healthy patient, and the sadness at seeing a friendly patient die. I remember an eternity of lectures, and the briefest of sleep during a night on call, and learning about personal gastroenterology at the VA Hospital cafeteria.

It has not been easy to be sure, but it has not been all that difficult. Underlying it all is a fascination with the human body that all persons share and we medical students have such a wonderful opportunity to explore. We understand so little and have so much to learn. We demand much of ourselves, yet need the help of so many others. However, lest you think of us becoming too much the technician, I believe we also see ourselves as the physician of a Norman Rockwell painting. There we sit, bespectacled and cheerful, allaying the fears of a concerned little girl, intently listening to the heartbeat of her doll. So for all of you who salute us now, we return the gesture. We will try not to let you down. ■

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Please see last page for brief summary, including warnings, precautions, and adverse reactions.

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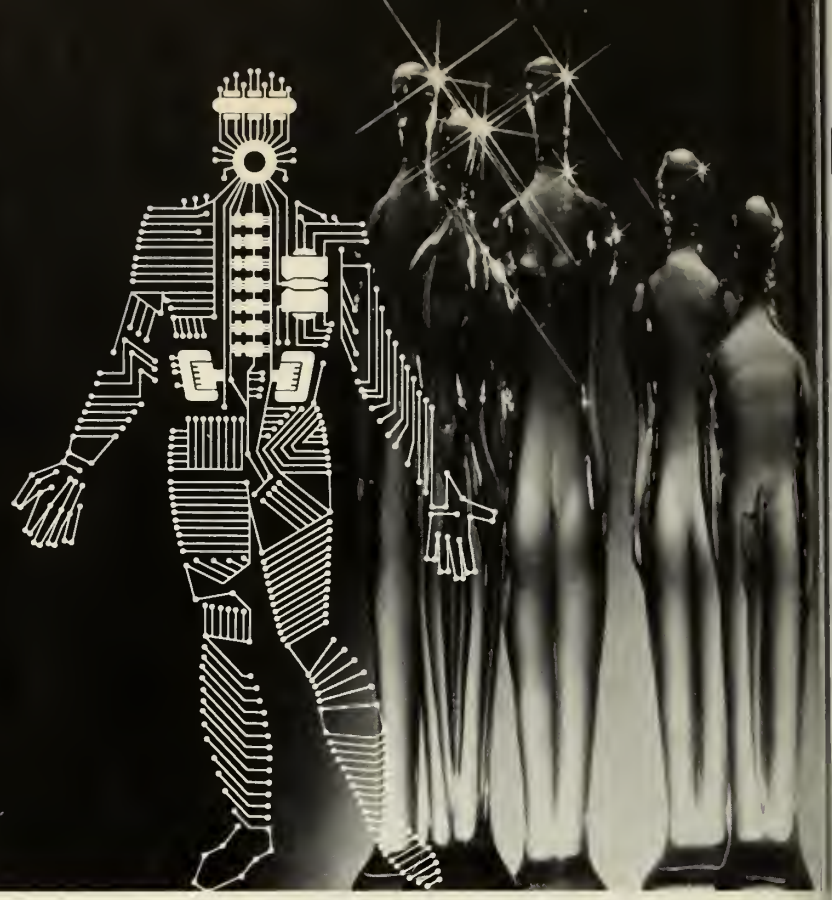

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Psychiatry in Rhode Island: 1725-1980

Expansion and Improvement of Psychiatric Programs in Rhode Island Will Result in Better Care for All

Sarah M. Saklad, MD

For the first 150 years of American history, poverty, crime, and insanity were regarded as natural components of human society. The local approach to providing social services reflected the seventeenth and eighteenth century view of the town as the basic unit of social organization. As early as 1725 Rhode Island had enacted laws to care for the indigent and mentally ill.

Samuel Green Arnold, historian and United States Senator, reported in 1860[1] that the first almshouse in Rhode Island was erected in 1723 in Newport by a vote of the town. On June 15, 1725 "the mainland towns were empowered to build a house of correction for vagrants and 'to keep mad persons in'. This is the earliest law in which mention is made of insanity in Rhode Island, as well as the disciplinary and reformatory institutions so numerous and well conducted at the present day in this state."

On October 27, 1742 the Rhode Island Assembly assigned the care of "insane and imbecile" persons to the town councils with the power to appoint guardians for their estates.

After the American Revolution and the beginning of the nineteenth century a new philosophy evolved: deviance was not inevitable, but was the result of poor environment. The solution was to isolate the poor, mentally ill, and the criminal in an environment that eliminated tension and chaos, which they felt were engendering deviant behavior. Poor farms and asylums sprang up around the country. In Providence Dexter Asylum was built.

The Dexter Asylum

Ebenezer Knight Dexter, Esquire, died on August 10, 1824, and by his "last will and testament devised a large and valuable property to the town of Providence to be applied, subject to certain conditions, to the support and maintenance of the poor of said town".[2]

One of Dexter's properties was his Neck Farm south of the Friends Yearly Meeting School (Moses Brown School). The town of Providence was to erect a suitable building within five years, and a stone wall around the farm three feet thick at the bottom and eight feet high. Also, the remainder of the estate, after bequests to family and friends, could be sold and a fund established from these assets for the benefit of the poor. This entire bequest was to be known as the "Dexter Donation". A commission was formed to administer the Dexter Donation; Cyrus Butler, a prominent Providence citizen, was one of the commissioners.

The building was finished in 1828 but the wall not until 1840. Besides the poor, the asylum provided care for insane or "deranged" persons who were lodged in "maniac" cells. The other inmates, the poor, were to help guard and secure them, and keep their cells in order. There was an attending physician who saw to it that sanitary con-

*Published in Boston, Charles C. Little & James Brown, 1838; reprint edition edited by Winfred Overholser, Cambridge, Harvard University Press, 1962.

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ditions were observed. Men and women were segregated, and no smoking in bed was allowed.

Legal residents of Providence were given preference; next were "aliens" (non-residents) who were living in Providence at the time.

In 1849 the asylum was crowded with 190 inmates. The problem arose as to how to handle this situation; to decrease the number of inmates or expand the facilities. Eventually the number of 170 was reached by attrition and that limit was set.

In 1884 the Dexter Asylum census showed 110 inmates; this number decreased gradually to 97 in 1906. During the depression of the 30s it rose again to reach 138 by June 30, 1934. From the end of the depression the census gradually decreased, apparently by attrition. On July 1, 1957 there were 22 inmates; 18 of these had died by September 30, 1957, leaving 4. In that year Brown University bought the Dexter Farm for a sum in excess of one million dollars.

Butler Hospital

The beginning of the nineteenth century saw the establishment in New England of several hospitals for the care of the mentally ill: McLean Hospital in Waverly, Massachusetts in 1818, the Hartford Retreat (now the Institute for Living) in 1824, the Worcester Asylum in 1831, and the Boston Lunatic Asylum in 1839.

Butler Hospital[3] had its origin in a bequest of thirty thousand dollars by the Honorable Nicholas Brown, who died in 1841. His will provided for a hospital "where that unhappy portion of our fellow beings, who are by visitation of Providence deprived of their reason, may find a safe retreat, and be provided with whatever may be conducive to their comfort and to their restoration to a sound state of mind". It was chartered by the state as the "Rhode Island Asylum for the Insane".

Dorothea Lynd Dix became concerned with the care and treatment of the insane in 1841 and inspired a drive for the improvement of their care in all of Massachusetts. After her Massachusetts campaign, she came to Rhode Island later that same year where she prevailed on Cyrus Butler, reputed to be the wealthiest man in New England and a bachelor, for financial support. Butler contributed forty thousand dollars, and an equal amount was to be raised publicly.

The hospital was built for sixty thousand dollars, and the remaining fifty thousand went into an endowment fund. On November 4, 1844 the Rhode Island Asylum for the Insane became Butler Hospital for the Insane. The hospital was opened in December, 1847 with Doctor Isaac Ray as superintendent. This appointment was fortunate because Isaac Ray was a remarkable man.

He was born in Beverly, Massachusetts in 1807, attended Phillips Andover Academy and Bowdoin

Butler Hospital, Providence, Rhode Island. Photograph in the Providence Public Library.

College in Maine in 1822 at a time when the students there included Henry Wadsworth Longfellow, Nathaniel Hawthorne, William Pitt Fessenden, Franklin Pierce, our fourteenth president, and Luther V Bell. Bell later became superintendent of McLean Asylum and the professional consultant to the founding Board of Trustees of Butler Hospital. It was Bell who suggested Isaac Ray for Butler Hospital's first superintendent. Doctors Bell and Ray were among the thirteen founders of the Association of Medical Superintendents of the American Institutions for the Insane, later the American Psychiatric Association. Isaac Ray received his medical degree from Bowdoin in 1827. He tried to practice medicine in Portland, Maine, but was not very successful. So he moved to Eastport in 1829, where he entered general practice.

His interest in medical jurisprudence first manifested itself in 1833, and in 1838 he published *'A Treatise on Medical Jurisprudence of Insanity'.** An edition appeared in Edinburgh in 1839 and in London soon afterwards. This was the first systematic exposition of medical thinking about insanity published in the United States by an American. It presented a synthesis of the Western world's thinking about insanity. In 1843 his treatise was the most referred to authority in the trial of Daniel M'Naughton.

This book was written by Ray before he was thirty-one while occupied with a private rural practice. It was so far ahead of its time that today's psychiatrists and lawyers are still trying to institute the reforms its author suggested. It was quoted in the Durham Trial in Washington, DC in 1954.

In 1841 Ray gave up his practice in Eastport to became the superintendent of the Maine Insane Asylum in Augusta, and in 1845 he was appointed superintendent-to-be of Butler. Since the hospital would not be ready for patients until 1847, he studied the asylums in Europe in the interim.

He retired from Butler Hospital at the end of 1866. He was committed to the treatment of the insane and the protection of their human rights. His "Treatise" was published in five editions in the United States, the last in 1871. Isaac Ray wrote about fifteen law journal articles on the jurisprudence of insanity. His concern for the insane evolved into concern for social justice on a broader scale. After his retirement, he came to visit the hospital annually, and when he died in 1887 he left seventy-seven thousand dollars to the hospital.[4,5]

In 1944 Winfred Overholser described Isaac Ray "as the most prolific writer, the most original, and the most forceful of all the thirteen founders (of the American Psychiatric Association). A man of broad interests, of rich humanity, and of vigorous mind, Isaac Ray is indeed one of the bright stars of the psychiatric firmament".[6]

Ray was followed by Doctor John W. Sawyer, a disciple of his, who in turn was followed by Doctor William B. Goldsmith on February 1, 1886. When Goldsmith died two years later, Doctor William A. Gorton took over and served as superintendent until he died on March 1, 1899.

G. Alder Blumer, another giant in American psychiatry, became superintendent at Butler Hospital on September 1, 1899. He was a man of superior education and culture, an Englishman, son of a physician, who came to this country at the age of twenty and attended the University of Pennsylvania Medical School. He interned for a year at the Lankenau Hospital in Philadelphia and then received an appointment on the staff of the New York State Lunatic Asylum in Utica. He was a gifted speaker and writer, contributing a number of articles to the *American Journal of Insanity,* which was published at the asylum at Utica. Blumer was installed as superintendent of the asylum in 1886, before his thirtieth birthday, and at the same time took over as editor of the *Journal.*

His first order as superintendent was to abolish all restraining apparatus. This order was complied with, and there appeared on the hospital lawn a miscellaneous collection which included two or three beds, know as "Utica cribs", in which patients could be restrained. There were also camisoles, muffs, restraining sheets, and the straight wooden chairs of heavy construction, which had been bolted to the floor in two wards. Kindling wood was placed beneath the pile, and, with as many supervisors, nurses, and attendants as could be spared for half an hour standing by, Blumer lectured to them briefly on the evils of mechanical restraints and upon measures which should be substituted. He then set fire to the kindling.

Since the Utica Asylum was a state hospital, and authority for its running centered in Albany, Blumer felt that not enough benefits were getting to the patients, or as many as he expected. He believed that local self-government for the mental institutions was better; so, when he was approached by the board of Trustees of Butler Hospital to take over as physician-in-chief and superintendent, he accepted and served for twenty-two years.

In 1901 he had "for the Insane" dropped from the name of Butler Hospital. His superintendency

was marked by his promotion of occupational therapy, the advancement of training opportunities for nurses and physicians, the stimulation of research, and the insistence on individual care and consideration for each patient.

Blumer was one of the early directors of the National Committee for Mental Hygiene, and a charter member of the Board of Directors of the Rhode Island Society for Mental Hygiene. He identified himself with all significant community projects and was, during his whole lifetime in Providence, recognized as one of our wisest and most forward-looking civic leaders.

He has been described by his successor, Doctor Arthur Hiller Ruggles, as the ideal superintendent emeritus. During his years of retirement he visited Butler Hospital almost every week. His visits were eagerly anticipated by old and new patients. These visits were always kept at a social level, and he invariably stopped at the office of the superintendent to make sure that his weekly visit was agreeable to him.[7]

Doctor Ruggles was Butler Hospital's third "giant". He came to the hospital at the age of twenty-four as a resident in psychiatry and after two years served as a rotating intern at the Rhode Island Hospital. In 1909 he returned to Butler Hospital. During the first World War he was a major in the army, returning to Butler Hospital in 1919.

He was one of the original members of the Rhode Island Association for Mental Hygiene in 1916 and its president from 1922 to 1925. Ruggles was a dynamic and influential individual with advanced ideas. He was responsible for organizing child guidance clinics in the local schools in 1916. In 1928 he was successful in persuading city officials of the need for a local facility for the temporary care of acute mental illnesses. At this time, too, he planned and organized the construction of Bradley Hospital, funded by Mr. and Mrs. George Bradley, for children with neurological and emotional illnesses. He retired as superintendent in 1948.

After his retirement, the Rhode Island Society for Mental Hygiene established the "Arthur H. Ruggles Annual Oration". Not only had he been a founder of the society, but he had also been a president of the Rhode Island Medical Society, president of the National Committee for Mental Hygiene for eight years, president of the American Psychiatric Association, and the first president of the International Congress on Mental Hygiene. The first oration was given by Doctor Carl A. L. Binger of Cornell Medical School on May 5, 1952. His opening remarks are worth quoting:

"To have been chosen to give the first Arthur Hiller Ruggles Oration on the occasion of the opening of Mental Health Week is an honor that perhaps I do not merit, but that I much appreciate. It is, moreover, an opportunity to pay just tribute to a man who has served his city, his state and his nation well, a man greatly loved and admired who has been a leader in his profession for many years and who has leavened the psychiatric loaf with his common sense, his tolerance, his open mindedness, his mature wisdom and his great kindness. This hospital (Butler) to which he has added so much luster has for long been a center of the best scientific tradition in psychiatry. To come here to speak to you, then, on any psychiatric subject is indeed like carrying owls to Athens, or, shall I say, like teaching Rhode Islanders to make Johnnycakes."[8]

Financial problems closed Butler Hospital in 1955; it was reopened in 1957 with fewer patients. Many of the psychiatrists who practiced in Rhode Island in this century received their training at Butler Hospital: Charles A. McDonald, Harvey B. Sanborn, Niles Westcott, Walter C. H. Weigner, Charles P. Fitzpatrick, who became superintendent at what is now the Institute of Mental Health in 1939, George H. Alexander, Ira C. Nichols, Gertrude L. Muller, Melvyn Johnson, and Charles C. Goodman. Many more have been trained there since the reopening of the hospital.

Rhode Island Hospital

In 1811 Brown University started a medical school that moved along fitfully, actually gaining strength before it finally closed in 1829. President Francis Wayland in 1827 had instituted regulations requiring that the medical school faculty reside on campus in order properly to discipline students. Since the doctors who taught at the school were mostly private practitioners, they were unable to comply, resulting in the demise of the school.

The Rhode Island Medical Society was founded in 1812 and the Providence Medical Association in 1848. In October of 1851, the Providence Medical Association, as proposed by its president Usher Parsons, appointed a committee of its members to consider the subject of a hospital in Providence and how it might most effectively be brought to the consideration of the public. They addressed a circular letter to every citizen in Providence who had been assessed with a tax of one hundred dollars. However, there was no significant

response. In 1852 the association addressed a petition to the city council, but still nothing happened. In 1857 Moses Brown Ives died and left fifty thousand dollars for "public beneficence". Ten thousand dollars was spent, and the remaining forty thousand dollars was set aside for future appropriation. In 1863 his brother, Robert Hale Ives, and his son, Thomas Poynton Ives, trustees of the fund, decided that this fund should go to the building of the Rhode Island Hospital and added thirty-five thousand dollars of their own. A general public appeal raised over two hundred thousand dollars in two months. At the time of the hospital's dedication, there was a fund of three hundred eighty thousand dollars from Providence, Newport and eighteen towns of the state.[9]

Professor William Gammell in reviewing the history of the Rhode Island Hospital up to the time of the dedication on October 1, 1868 hoped that "with the aid of the Rhode Island Hospital may we not have a Rhode Island Medical School again associated with our own university, as there used to be some forty years ago?"[10]

In the annual reports of the Rhode Island Hospital, beginning in 1876, the medical and surgical diseases diagnosed in the patients admitted the previous twelve months were given. Among the medical diseases listed that year and in several ensuing years were hysteria, insanity, acute mania, masturbation, melancholia with suicidal intent, delirium tremens, and alcoholic dementia. The reports included condition at discharge: "cured, relieved, unrelieved, or died".

In 1897 a department of neurology was established with two staff physicians, Doctors Eugene Kingman and George L. Shattuck. In 1899 G. Alder Blumer, the newly arrived superintendent of Butler Hospital was appointed a consulting physician. The hospital now had a nursing school. In the annual report for 1900 Doctor Blumer is listed as a lecturer to the student nurses on "the care of the nervous and insane; what to do for special forms of insanity; occupation for the invalid and convalescent". Doctor Shattuck lectured on "chorea, neurasthenia, epilepsy, hysteria, rest care".

From 1906 most of the neuropsychiatrists who practiced in Rhode Island interned at the Rhode Island Hospital. The department of neurology grew, and in 1915 four neurologists on the staff were also assigned to supervise the outpatient department. In 1940 a specific junior staff was appointed to the outpatient department. Psychometrists were also appointed to this department part time.

It was not until 1941 that the Rhode Island Hospital officially recognized psychiatry by listing a "department of neurology and psychiatry".[10]

In the original hospital building there was a Ward L in the basement for neurological and psychiatric patients. The new hospital building was opened in 1955 at which time Doctor William Newton Hughes was chief of neuro-psychiatry. There were a few psychiatric beds on Ward 9B with two rooms especially outfitted as seclusion rooms. With each succeeding year the demand for psychiatric treatment in this general hospital increased. In 1964 unit 6A was opened with eighteen beds for the admission of patients with emotional problems. The two special rooms on 9B remained for psychiatry. In 1967 a separate department of psychiatry was established with Doctor David J. Fish as its chief.

The Institute of Mental Health

In 1864 a Committee was appointed by the Rhode Island General Assembly to inquire into the expediency of erecting a state asylum for the insane. Two years later a State Board of Charities and Corrections was established similar to that in Massachusetts to "devise a better system of caring for the unfortunate and unlawful classes of the State". The act that created the Board provided for the establishment of a state workhouse, a house of correction, a state asylum for the incurably insane, and a state almshouse. Two Cranston farms, the old Stukely Westcott farm belonging to Thomas Brayton, and the William A. Howard farm were acquired. Eighteen frame buildings were built in 1870, and in November, one hundred eighteen mental patients were admitted: sixty-five charity cases from Butler Asylum, twenty-five from town poorhouses, and twenty-eight from asylums in Vermont and Massachusetts, where the State had sent them.

Therapy was the least of the purposes considered here. The commissioners chose as a model the Asylum on Blackwells Island in New York City which had one of the worst reputations in the nation for patient care, but also the lowest annual cost per patient. Originally our institution was intended for custodial care of chronic patients and was not really a hospital. In 1885, the Assembly voted that the Asylum should care for all indigent insane as well as the chronic, but no provision was made for adequate medical treatment.

A report of the secretary of the State Board of Charities and Corrections states that "the asylum is for the incurable pauper insane and no insane person should ever be received into it until he has

Rhode Island State Hospital, Howard, Rhode Island, reprinted from *Providence Magazine,* February, 1916.

had an opportunity of receiving treatment in a good hospital. I think we can safely adopt this rule and this only, not to receive any insane into the State Asylum until they are pronounced incurable by a competent authority".

In 1897 a medical superintendent was finally appointed after repeated and insistent urging by the medical profession. Under the leadership of Doctor George F. Keene, the Rhode Island State Hospital became a fact, although buildings and funds were insufficient. In 1906 a resolution was introduced in the legislature urging establishment of a state school for the care and education of feebleminded children. This legislation resulted later in the school at Exeter, now known as the Ladd School, named for its first and long-time medical director, Doctor Joseph Ladd.

Doctor Fred B. Jewett, assistant superintendent under Doctor Keene, succeeded him at his death and Doctor Arthur H. Harrington became superintendent when Doctor Jewett resigned. Doctor Harrington was a public-minded individual and publicized the needs of the institutions for mental patients and educated the legislature. Doctor Ranson H. Sartwell, Doctor Harrington's successor, was superintendent for only a short time. He was shot to death in his study on the hospital grounds by an escaped paranoid patient.

Doctor Arthur P. Noyes, his successor, was a distinguished and nationally known psychiatrist. His textbook, *Modern Clinical Psychiatry*, is still in print and is used as a reference for medical students. He was able to influence Governor Theodore Francis Green, so that in 1935 a bond issue was approved by the voters for an extended building and equipment program.

By 1940 crowding at the State Hospital was unbelievable: thirty-two hundred patients in buildings planned to hold eighteen hundred. With the advent of shock therapy the census began to go down. Beginning in 1956, first with the use of chlor-promazine, and later with the newer psychopharmacological drugs added, many patients were greatly improved and could be discharged. Over the next twenty years the crowding gradually disappeared. Currently the hospital houses around eight hundred patients. Much has happened there in the last five years, with many improvements. It is hoped that the improvements will continue.

In 1962 the General Hospital and the State Hospital for Mental Diseases was designated the Rhode Island Medical Center, and soon thereafter the psychiatric part was designated as the Institute for Mental Health.[11]

The Mental Hygiene Movement and the Providence Child Guidance Clinic

On April 13, 1909 a luncheon meeting was held in Providence attended by nearly one hundred men and women who were dealing with the problems of

distress and maladjustment in the community, in order to learn to work effectively together rather than alone. The first State Conference of Charities and Corrections followed on November 23, 1909. Judge Baker presided and papers were presented by Doctors Arthur H. Harrington, Arthur H. Ruggles, Henry C. Hall, George A. Blumer, John E. Donley, Jr., Joseph H. Ladd, and Charles V. Chapin, among others. For the first time in history the whole state as a unit became involved in dealing with matters of vital social significance. Many of the papers dealt with problems of children of all ages and how to deal with them.

These conferences continued annually for fifteen years. In 1913 Clifford W. Beers, a former patient at Butler Hospital and the author of *The Mind that Found Itself,* addressed the conference. He had founded the Connecticut Society for Mental Hygiene in 1908 and the National Committee for Mental Hygiene in 1909. He was the stimulant that resulted in the formation on March 21, 1916 of the Rhode Island Society for Mental Hygiene.

At first the society focused on public education, calling attention to gaps in services, to the inadequacies of the laws, and the need for better care for those with emotional problems. In November, 1916 a mental hygiene clinic was opened at 272 Thayer Street and met one evening a week with Doctors McDonald, Arthur H. Ruggles, Fred J. Farnell, and Clinton S. Westcott giving their services and with a nurse with psychiatric training in attendance. This clinic functioned for a year until the demands of World War I depleted the personnel.

In 1922 a psychiatric social worker, Miss Esther F. Greene, was appointed executive director of the society. She developed an educational program with lectures, conferences, pamphlets, articles, and meetings to spread the message of mental hygiene throughout the state, introducing the new idea that "abnormalities of behavior have their beginnings in early childhood and grow out of disturbed parent-child relationships".

The following year a demonstration clinic was opened in Central Falls a half day a week with a team consisting of a psychiatrist, psychologist, and social worker to treat school problems. Children with behavior problems were treated with remarkably good results.

On October, 1925 the society hired its first full-time team of psychiatrist, psychologist, and psychiatric social worker. At the same time the Esek Hopkins Mental Health Center was opened, similar to the Central Falls Clinic. During these last two years some voluntary work was done with the Juvenile Division of the Sixth District Court.

Three years later the Esek Hopkins Mental Health Center and the Juvenile Court Clinic became the Providence Child Guidance Clinic. During the depression years of the '30s the clinic had great financial problems. However, it developed a professional training program with second year students from Smith College of Social Work, later taking students from many schools in New England and Columbia University. At this time the clinic was housed at 100 North Main Street.

The clinic continued to grow during the World War II years and afterwards despite the continued shortage of financial help. Part-time clinics were opened in Cranston, Warwick, and Pawtucket. In April 1950, when the clinic was incorporated as an entity apart from the Rhode Island Society of Mental Hygiene, it became the only facility in the state competent and equipped both to diagnose and give long term treatment for people of all means. Five years later the clinic was approved as a medical training facility.

Doctor Hector C. Jaso took over as director on October 1, 1957. Six months later the clinic moved to new, attractive, and more commodious quarters on the grounds of Butler Hospital. By September the staff had grown to eight members, six full-time and two on a half-time basis. In 1962 a training grant from the National Institute of Mental Health brought the first fellow under the approved training program. Now Doctor Jaso was able to offer pediatric residents at the Rhode Island Hospital an opportunity to gain some knowledge and experience in child psychiatry.

In 1973 the Providence Child Guidance Clinic became the Rhode Island Youth Guidance Center in order to reflect its acceptance of children and adolescents from the entire state. Since then it has developed a close relationship with the Pawtucket-Central Falls Mental Health Center and is currently occupying quarters at 82 Pond Street in Pawtucket, adjacent to the Pawtucket Memorial Hospital and its Family Care Center.[12]

Charles V. Chapin Psychopathic Unit

The Providence City Hospital was opened on March 1, 1910 for the treatment of contagious diseases at the behest of Doctor Charles V. Chapin, the remarkable Superintendent of Health of the City of Providence. He was the originator of an isolation technique for the treatment of these illnesses.

The City Council passed a resolution on December 7, 1931 to change the name of the Providence City Hospital to the Charles V. Chapin Hospital. Doctor Chapin resigned as superintendent of health in January 1932 after forty-eight years of distinguished service.

It has already been mentioned that in the mid-'20s Doctor Ruggles was able to persuade Providence city officials of the need for a facility for the diagnosis and treatment of acute psychiatric illness. Under instructions from the City Council the City Solicitor applied to the General Assembly early in 1928 for authority "to hire the sum of seven hundred thousand dollars for hospital purposes". The resolution was approved on May 18, 1928.[13] This sum was to cover the cost of constructing the psychiatric wards, a nurses' home, and several plant improvements.

Early in 1929 the General Assembly passed Chapter 1447 "An Act Relative to Admission and Treatment of Patients at the Psychopathic Wards of the Providence City Hospital".[14] This legislation provided for the 15-day commitment of any person found within the City of Providence in need of immediate care and treatment because of a mental disorder, other than drunkenness, upon the request of a licensed physician. Anyone found outside the city but within the state could be admitted, provided satisfactory financial arrangements could be made. If a patient needed more extensive hospital care, he could be transferred to the State Mental Hospital or Butler Hospital. The act also provided for voluntary admissions to the unit, preference being given to Providence residents.

In the twenty-first Annual Report of the Providence City Hospital, December 31, 1930, Mayor James E. Dunne reported that the first patient, a female, was admitted to Ward I on June 3, 1930.

He went on to say that R. H. Ives Goddard, a member of the Board of Commissioners of the Providence City Hospital during the planning of the Psychopathic Wards, and one of the trustees of Butler Hospital, allowed Doctor Ruggles to consult almost constantly with Doctor Dennett L. Richardson, the superintendent of the Providence City Hospital. Doctor Ruggles gave his services without compensation. He thus had the assistance "of the best psychiatrist in the country". Butler Hospital loaned Doctor George Eliot, who had had experience at the Boston Psychopathic and Butler Hospitals, to the City Hospital to be director of the new facility for a few months until a capable clinical director could be appointed.

The male and female wards, the second and third floors respectively, each had thirty-five beds, and in the pre-World War II years were adequately staffed by a supervisor, three graduate nurses trained in psychiatry and nine attendants on day duty. There was also one psychiatric nurse and four attendants on night duty. In the early years of the hospital, nurses and attendants worked twelve hour shifts. In one wing of the first floor were located the psychiatric staff offices, and in the other the outpatient department. The psychiatric service was a very busy one. Since many of the patients with acute mental symptoms presented complicated medical problems, the ready availability of medical services was advantageous.

The hospital had a separate building for patients with pulmonary tuberculosis, but with the development of antitubercular drugs in the post-World War II years, tuberculosis was phased out and the building was remodeled with thirty-seven beds for the less disturbed female patients. Antibiotics and poliomyelitis vaccine markedly reduced the need for beds for contagious diseases, for which the Providence City Hospital was originally built in 1910. As a result, one of the other units was converted to house sixteen males who could be cared for on an open ward.

On July 1, 1965 the City of Providence leased the hospital to the state for one dollar a year, since most of the patients being admitted at that time were not from Providence. In 1966 the entire hospital was converted to psychiatry, but this was gradually changed, so that by 1971 it was used to treat alcoholics and to screen patients for admission to the Institute of Mental Health.

In 1974 the city sold the hospital buildings and grounds to Providence College to be used for academic purposes.

Emma Pendleton Bradley Hospital

In the late 1920s it was apparent that there was no hospital available for the diagnosis and treatment of children with convulsive disorders, birth injuries of the nervous system, nervous symptoms from encephalitis lethargica, or behavior problems. Doctor Ruggles felt that the need for such a facility was urgent and persuaded Mr and Mrs George Bradley to finance such an undertaking.

The hospital was dedicated on April 8, 1931 with Doctor Ruggles serving as superintendent until 1941. He also served as chief of staff until 1960. The building provided housing for fifty children suffering from disorders of the nervous system. The carefully selected staff coordinated education and recreation as well as diagnosis and medical treatment of the patients in a residential setting.

Doctor Charles Bradley, a grandnephew of the founders, came there to intern in 1932 after completing his pediatric training. He was the medical director from 1933 to 1941, then superintendent until 1948, when he accepted an appointment as associate professor of pediatrics and psychiatry at the University of Oregon Medical School. The pioneer work in the effective use of amphetamines for hyperkinetic children was conducted there by Doctor Bradley. Under his direction the hospital became a nationally recognized clinical center for the treatment of children with neuropsychiatric disorders. Within a short time an intern and residency training program was established.

Herbet Jasper, PhD, came there in September 1933 and remained until 1941 to develop a laboratory for psychological research. He concentrated chiefly in the development of electroencephalography, working with both undergraduate and graduate Brown students. Doctor Jasper, in fact, was one of the pioneers in electroencephalography. Doctor Donald Lindsley followed Doctor Jasper and remained until 1946.

Doctor Maurice W. Laufer was an assistant resident there in 1942 and returned in 1946 to become the clinical director. When Doctor Bradley left, Doctor Laufer succeeded him as medical director and later superintendent. In the '70s he became president of the hospital and professor of psychiatry at Brown. He held these positions until his death in 1978.

Under Doctor Laufer the hospital grew and expanded its services, research, and teaching. After the post-war adjustment, the hospital was approved for residency training. In 1961 a pre-school day care project was started for children under six years of age who presented diagnostic problems or had some abnormality of behavior. In this special setting they could be studied by the coordinated services and various disciplines. A guidance center was opened in 1963, and in 1964 Swan House, a half-way house for eight boys, was established.

When Brown University's medical program was approved for granting the MD degree, Bradley Hospital became an integral part of its teaching program in child psychiatry. Much research has been conducted at Bradley over the years with many contributions to medical literature.

Community Mental Health Centers

Psychiatric services grew and developed in Rhode Island just as they did nationally after World War II. On April 30, 1948 the state legislature passed a bill H.658, "An Act to extend and strengthen the Mental Hygiene Services in this State and Designating the State Department of Social Welfare as the Agency in Rhode Island to cooperate with the Federal Government".

With this new service, psychiatric clinics were opened in many parts of the state, mostly one day a week, and were served by a traveling team. These clinics were to be the forerunners of the Community Mental Health Centers.

The Community Mental Health Services Act, 26-7-1, was passed in 1962, authorizing local mental health programs. the Division of Social Welfare was given the authority to make grants to assist cities and towns or non-profit corporations in the establishment and operation of these programs. They were to provide: (1) collaborative and cooperative services with public health and other groups for programs of prevention of mental illness, mental retardation, and other psychiatric disabilities; (2) informational and educational services to the general public and lay and professional groups; (3) consultative services to schools, courts, and health and welfare agencies, both public and private; (4) outpatient diagnostic and treatment services; (5) rehabilitative services for patients suffering from mental and emotional disorders, mental retardation; and other psychiatric conditions, particularly those who have had prior treatment in an inpatient facility.

The Community Mental Health Centers were gradually developed in the late '60s. The first was established in Newport in connection with a grant awarded to Newport Hospital to expand its bed capacity. The plan included provision for inhospital psychiatric beds. Next came the Providence Mental Health Center, which has grown vigorously since its inception in 1968. With its multiple services, it is able to forestall the admission of mentally ill patients to the Institute of Mental Health, since it has an arrangement with Butler Hospital to care for its acute cases. Urgent problems are seen at the emergency service of the Rhode Island Hospital. There are now five other Community Mental Health Centers in the state.

Brown University Medical School Department of Psychiatry

Brown University inauguated a six year medical program in 1963. It planned to award both bachelor and master of science degrees at the end of the sixth year. The planners of this program hoped that these students would continue in medical science research. There were no plans for any psychiatric teaching in the fifth and sixth years. In an attempt to make up for this deficiency, Doctor Frederick W. Barnes, Jr created an innova-

tive program that offered the students an unusual approach to psychiatry through drama. Doctor Barnes's program used professional actors from Providence's Trinity Square Repertory Company to give students insights into behavioral problems. These live dramatic performances, from such plays as "Death of a Salesman" and "A Streetcar Named Desire", were followed by clinical psychiatric discussions with a psychiatrist from Boston. The graduates of this program for the most part went on to medical school and several have become practicing psychiatrists.

Brown was accredited as a four year medical school effective during the 1970-71 academic year. Doctor Ben Feather came to Providence on July 1, 1971 as superintendent of Butler Hospital as well as professor and chief of psychiatry at the Brown University Medical School. He soon expanded both his staff and research at Butler Hospital, while developing a teaching program.

With this development the Providence Veterans Administration Hospital was authorized to expand its program for treatment, research, and teaching in psychiatry. The Emma Pendleton Bradley Hospital was an excellent teaching facility for pediatric psychiatry. Before long both The Miriam and Pawtucket Memorial Hospitals developed effective teaching programs. Some of the psychiatric staff at the Rhode Island Hospital were also involved in teaching. In 1978 the Rhode Island Hospital appointed a full-time chief of psychiatry, charged with the task of developing an academic department in psychiatry with a close relationship with the department of medicine. The current superintendent of Butler Hospital, Doctor Nathan Epstein, continues as the chairman of the department of psychiatry at the Brown University Medical School.

The expansion and improvement of the psychiatric programs in Rhode Island have attracted many bright young physicians to the community. The teaching programs at Brown are helping to make the students more aware of and interested in the emotional problems of patients in all fields of medicine. The results of these changes will be better care for all of the people of Rhode Island and will reflect the commitment of the community to the recognition and solving of the problems of mental health.

References

[1]Arnold SG: History of the State of Rhode Island and Providence Plantations 1859-1860. Providence, RI, Preston & Rounds, 1899.

[2]The Dexter Donation and the Dexter Asylum of the City of Providence. Providence, RI, City Document, No. 26, 1879.

[3]Trustees and Superintendent of Butler Hospital: The Butler Hospital, Its Story Published in 1926. Providence, RI. Butler Hospital, 1926.

[4]Quen JM: Isaac Ray. Have we learned his lessons? Read at Isaac Ray Symposium on Human Rights, the Law, and Psychiatric Treatment, Butler Hospital, Providence, RI, May 24, 1974.

[5]Quen JM: Isaac Ray and his "Remarks on Pathological Anatomy". Bull Hist Med 38:113-126, Mar-Apr 64.

[6]Overholser W: The founding and the founders of the Association, in Hall JK, et al (eds): One Hundred Years of American Psychiatry. New York, Columbia University Press, 1944, pp 45-72.

[7]Blumer GA: The first four editors: Amariah Brigham, founder and first editor of "American Journal of Insanity"; T. Romeyn Beck; John P. Gray; G. Alder Blumer, (R.H. Hutchings). Amer J Psychiat 100:29-40, Apr 44.

[8]Ruggles AH: In memorial 1881-1961. Amer J Psychiat 118:93-94, Jul 61

[9]Goldowsky SJ (ed): The History of the Rhode Island Medical Society and Its Component Societies 1812-1962. East Providence, RI, Roger Williams Press, 1966.

[10] The Rhode Island Hospital Annual Reports 1869-1941. Providence, RI.

[11] Rhode Island Historical Preservation Commission: The State Institutions at Howard, A History and Inventory. Providence, RI, 1978.

[12] Bousquet KT: The Providence Child Guidance Clinic: A Brief History, 1925-1969. Providence, RI.

[13] City of Providence Annual Report 1929, resolution 237. Providence, RI.

[14] Report of the Providence City Hospital for the year ending December 31, 1929. Providence, RI.

[15] Report of the Providence City Hospital for the year ending December 31, 1930. Providence, RI.

[16] The Emma Pendleton Bradley Annual Reports 1932-1974. Riverside, RI.

266 Slater Avenue
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Remarks on Doctor Isaac Ray (1807-1881)

He Was Unquestionably the Preeminent Psychiatrist in Nineteenth Century America

Jacques M. Quen, MD

There is an Isaac Ray building at the Maine State Hospital in Augusta. There is an Isaac Ray Psychiatric Clinic in Chicago. The American Psychiatric Association honors an outstanding individual with its Isaac Ray Award. We are here today to rededicate Ray Hall. Despite this apparent fame, not many appreciate who and what he was. I should like to tell you about Isaac Ray, the man whose name is inextricably linked with Butler Hospital, with clinical excellence, and with psychiatric education.

He was born in Beverly, Massachusetts in 1807, the first child of a Yankee sea-captain and his second wife. Isaac Ray graduated from Phillips Academy at Andover at the age of 15. He enrolled in Bowdoin College during its remarkable decade when the student body included Henry Wadsworth Longfellow, Nathaniel Hawthorne, William Pitt Fessenden, America's fourteenth president Franklin Pierce, and one who was to play another important role in the history of Butler Hospital, Luther V. Bell.

Perhaps because of ill health, Isaac Ray dropped out of Bowdoin, unexpectedly, in 1824. He began the study of medicine that same year and returned to Bowdoin in 1826 to complete his formal medical education. Of the subsequent period, he later wrote, "At the tender age of 20, being a member of the medical profession in regular standing, I offered my services as practitioner of medicine and surgery to the people of Portland in 1827. They manifested no vehement desire to avail themselves of this privilege, and thinking my services might be better appreciated somewhere else, I removed in 1829 to Eastport, where I resided till 1841."

Isaac Ray, MD (1807-1881). Photograph by Matthew Brady, reprinted courtesy of Butler Hospital, Providence, Rhode Island. The original is in the Library of Congress.

Presented at Butler Hospital, Providence, Rhode Island, at the re-dedication of Ray Hall on January 10, 1980.

Jacques M. Quen, MD, Clinical Professor of Psychiatry, Associate Director of the Section on the History of Psychiatry, Department of Psychiatry, New York Hospital-Cornell Medical Center, New York.

In 1831 he married Abigail May Frothingham. In 1832 their daughter Abby was born. In December 1836, a son, Benjamin Lincoln completed their family. That same year he was a founder of the Eastport Athenaeum, a self-improvement society and library.

In 1838, Ray published his book, *A Treatise on the Medical Jurisprudence of Insanity*. The successful defense in the famous 1843 trial of the insane Daniel M'Naghten made extensive and almost exclusive reference to the work of Isaac Ray. It was the first time that an American physician was accorded such status in a British court. Written by a 31 year old general practitioner, who had received all his education in America, with no significant training or experience in insanity or the law, in a small seaport town of about 2500 souls, far from any legal or medical center, the book remains a classic worth reading and is read by psychiatrists today.

Move to Providence

In 1841, Ray became the superintendent of the Maine Insane Hospital in Augusta. In 1844 he was one of the original thirteen founders of the Association of Medical Superintendents of American Institutions for the Insane, later called the American Psychiatric Association. It was the first and now is the oldest of American medical specialty organizations. The Superintendent of McLean Hospital, Luther V. Bell, was a fellow founder of that organization and, also, the consultant to the Board of Trustees of the yet-to-be-built Butler Hospital. It was he who suggested Isaac Ray for the position of superintendent in 1845 and who worked intimately with Ray and the Board in planning the construction and facilities of this hospital.

In 1846, before the family moved to Providence, the Rays' 14 year old daughter died of a consumptive disease. In December 1847, Butler Hospital received its first patient. It was customary in those days for the managements and the superintendents of the insane hospitals to publish annual reports of the state of the institutions for general dissemination to the public and to other asylums and hospitals. Ray used these annual reports as vehicles for educating the public about the causes, treatments, and other aspects of insanity. He also used them to discuss current issues in law, legislation, and clinical practice regarding the care of the insane. Ray's reports were of such quality that they were often reprinted in the professional publication, the *American Journal of Insanity*.

Butler Hospital and Isaac Ray achieved national and international recognition for excellence. In 1856, when Luther V. Bell was preparing to resign the superintendency of McLean Hospital, the Trustees of that prestigious institution offered Ray the post. In the letter notifying the Butler Hospital Trustees of his rejection of that offer, he wrote, "In going elsewhere I might find a wider field of distinction, but I am sure I could not find a body of friends more ready to give me their sympathy and support in my official duties, or more disposed to magnify my deserts and make allowances for my shortcomings." Truly, the relation between the trustees, the superintendent, and the hospital was one of unique closeness, personal involvement, and collaboration.

During this period, Ray was president of the Superintendents' Association and president of the Rhode Island Medical Society. In 1863, he published a book designed for the general public on the subject of *Mental Hygiene*. Meanwhile, Ray had been troubled by the shortage of recreational opportunities for the patients at Butler. In 1864, he notified the Board of Trustees that two gentlemen had agreed to donate a building to house bowling alleys, billiard tables, a museum, a reading room, and other forms of recreation for the patients. The building was completed in 1866 at a cost of $38,000. That same year, Isaac Ray was in such poor health that he no longer felt equal to the task of superintending the hospital, and he submitted his resignation. His son, Benjamin Lincoln Ray, who had received his medical degree from Harvard and had served as assistant physician to his father since 1859, also resigned. Isaac Ray had been Superintendent of the Butler Hospital for twenty-one years. In 1868, Robert H. Ives and Alexander Duncan, the donors of the recreational building, proposed that it be named Ray Hall, and so it was.

Retirement

Ray retired to Philadelphia for reasons that are not clear, although he probably left Providence to allow his former assistant and successor, Doctor John W. Sawyer, a free hand to make whatever changes he would in the hospital program. Doctor Sawyer and Isaac Ray remained good friends and in close contact for the rest of Ray's life. In 1869, Isaac Ray was one of the founders of the reform-oriented Philadelphia Social Science Association. He was a member of the Board of Guardians of the Poor of Philadelphia (the governing body of the Philadelphia Almshouse Hospital, later known as the Philadelphia General Hospital). Between 1870 and 1873 he gave three courses of lectures on

insanity to the students at the Jefferson Medical College. He continued to publish articles on law and psychiatry and on the care of the insane, and reviews of psychiatric books and reports. In 1873 he gave a public address at a meeting of the Philadelphia Social Science Association titled "What shall Philadelphia do for its paupers?", in which he provided facts, figures, and measurements exposing the inadequacies, abuses, and dangers for patients in all departments of the almshouse hospital, including the insane department. His appointment to the Board of Guardians of the Poor was not renewed that year, an act that was seen as a political retaliation to justified criticisms from a qualified professional.

In 1873, Ray presented a paper, at the annual meeting of the Superintendents' Association, titled "Ideal characters of the officers of a hospital for the insane." In it he describes a dream in which he found an old manuscript, with that title. He said he reproduced the manuscript from memory. I regret that time doesn't allow me to read the paper to you. In it are described the qualities of a good superintendent, assistant physician, wife of the superintendent, and director (or trustee) among others. It is an instructive and revealing essay.

Doctor John P. Gray, who was editor of the *American Journal of Insanity,* superintendent of the Utica State Hospital in New York State, and a long-time critic of some of Ray's views on insanity, responded to the paper with a poem which was printed privately. Titled "The Dream of the Master", Gray wrote, in part,

> "'The Good Superintendent.'" who is he?
> The master asked, again and again,
> But answered himself, unconsciously,
> And wrote his own life, without a stain.
> Long since done with such duties he
> But the thoughts of his heart were in them yet.
> And in his dreams the master would be
> Working out problems: — How could he forget?

Gray closed the poem with:

> And gently dreaming out thy life,
> Awake to hear the Great Master say:
> "Well done 'The Good Superintendent,' thou
> Enter my school, good Master Ray."

In 1879, Benjamin Lincoln Ray died suddenly of an unspecified brain disease at the age of 43. Abigail and Isaac Ray were grief stricken, and Isaac Ray's physical condition deteriorated. He died in his sleep on March 31st, 1881, of tuberculosis. Benjamin Lincoln Ray, Isaac Ray and Mrs. Abigail Ray were buried at the Swan Point cemetery adjoining the Butler Hospital grounds. Upon the death of Mrs. Ray in 1885, the bulk of the Ray Estate was left to Butler Hospital, to be used at the discretion of the Trustees. I said earlier that the birth of Benjamin Lincoln Ray completed the Ray family. I think you can see that I was incorrect. In fact, it was Butler Hospital that completed Isaac Ray's family.

Assessment

Unquestionably, he was the preeminent psychiatrist in nineteenth-century America. He was a founder of the American Psychiatric Association, a founder of the Philadelphia Social Science Association, the first Superintendent of the Butler Hospital, a founder of the Eastport Athenaeum, and a founder of forensic (or legal) psychiatry as a discipline with its own body of knowledge, expertise, and skills. His *Treatise* was written for the "professional student", his superintendent's reports were written to educate the public and the profession about insanity, and his courses of lectures at the Jefferson Medical College were designed to instruct general practitioners. We would be hard pressed to find a more appropriate use for Ray Hall than that of a conference and educational center. I think "good Master Ray" would have liked that.

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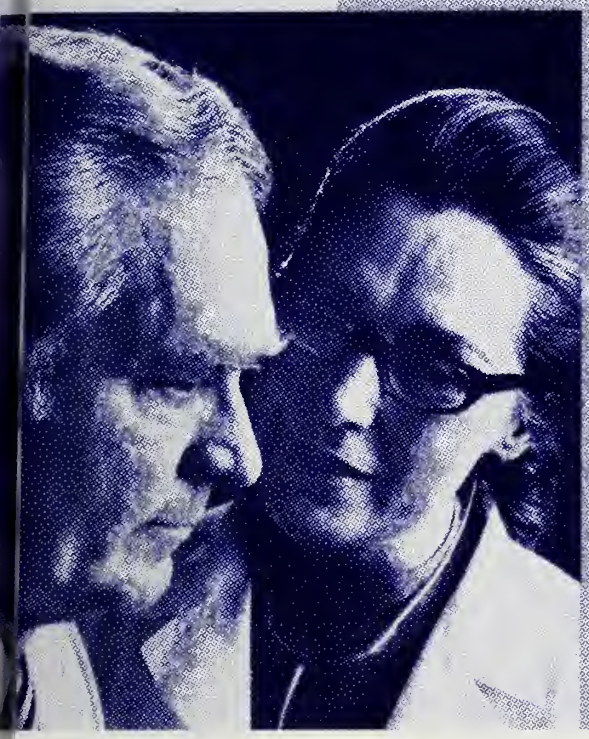

The published record on Librium is enormous. So large, in fact, it had to be put into a computer data bank and retrieval system. It's a record that shows Librium is highly effective in relieving anxiety; that Librium is seldom associated with serious side effects; that Librium rarely interferes with mental acuity at proper doses; that Librium is used concomitantly with primary medications. However, as with all CNS agents, patients should be warned against hazardous activities requiring complete alertness, and about possible combined effects with alcohol.

performance

Librium® ℞
chlordiazepoxide HCl/Roche

5mg, 10mg, 25mg capsules

synonymous with relief of anxiety

- An unsurpassed safety record
- Minimal effect on mental acuity, in proper dosage
- Predictable patient response
- Is used concomitantly with primary medications, such as anticholinergics and cardiovascular drugs

Please see next page for summary of product information.

Librium® 5mg, 10mg, 25mg capsules
chlordiazepoxide HCl/Roche

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of anxiety and tension occurring alone or accompanying various disease states. Efficacy beyond four months not established by systematic clinical studies. Periodic reassessment of therapy recommended.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Warn patients that mental and/or physical abilities required for tasks such as driving or operating machinery may be impaired, as may be mental alertness in children, and that concomitant use with alcohol or CNS depressants may have an additive effect. Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage. Withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported.

Usage in Pregnancy: **Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Usual Daily Dosage: Individualize for maximum beneficial effects. *Oral—Adults* Mild and moderate anxiety and tension, 5 or 10 mg *t.i.d.* or *q.i.d.*; severe states, 20 or 25 mg *t.i.d.* or *q.i.d.* *Geriatric patients* 5 mg *b.i.d.* to *q.i.d.* (See Precautions.)

Supplied: Librium® (chlordiazepoxide HCl) *Capsules*, 5 mg, 10 mg and 25 mg—bottles of 100 and 500. Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Paks of 50, available singly and in trays of 10. Libritabs® (chlordiazepoxide) *Tablets*, 5 mg, 10 mg and 25 mg—bottles of 100 and 500. With respect to clinical activity, capsules and tablets are indistinguishable.

ROCHE

Roche Products Inc
Manati, Puerto Rico 00701

Quinamm™

AVAILABLE ONLY ON PRESCRIPTION

Brief Summary

INDICATIONS: For the prevention and treatment of nocturnal recumbency leg muscle cramps, including those associated with arthritis, diabetes, varicose veins, thrombophlebitis, arteriosclerosis, and static foot deformities.

CONTRAINDICATIONS: Because of the quinine content, Quinamm is contraindicated in women of childbearing potential, in pregnancy, in patients with known quinine sensitivity, and in patients with glucose-6-phosphate dehydrogenase deficiency. Hemolysis (with the potential for hemolytic anemia) has been associated with a G-6-PD deficiency in patients taking quinine.

PRECAUTIONS: Thrombocytopenic purpura may follow the administration of quinine in highly sensitive patients. Recovery will follow withdrawal of the medication.
Cinchona alkaloids, including quinine, have the potential to depress the hepatic enzyme system that synthesizes the vitamin K-dependent factors. The resulting hypoprothrombinemic effect may enhance the action of warfarin and other oral anticoagulants.

ADVERSE REACTIONS: Aminophylline may produce intestinal cramps in some instances, and quinine may produce symptoms of cinchonism, such as tinnitus, dizziness, and gastrointestinal disturbance. If ringing in the ears, deafness, skin rash, or visual disturbances occur, the drug should be discontinued.

DOSAGE AND ADMINISTRATION:
1 tablet upon retiring. When necessary, 1 additional tablet may be taken following the evening meal.

Product Information as of September, 1977

U.S. Patent 2,985,558

Merrell

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Cayey, Puerto Rico 00633

Direct Medical Inquiries to:
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each tablet contains quinine sulfate 260 mg., aminophylline 195 mg.

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Nocturnal recumbency leg muscle cramping is frequently an unwelcome bedfellow for many patients—especially those with arthritis, diabetes or peripheral vascular disease... consider Quinamm... simple, convenient dosage—usually just one tablet at bedtime... can provide restful, welcome sleep without night leg cramps.

See opposite page for prescribing information.

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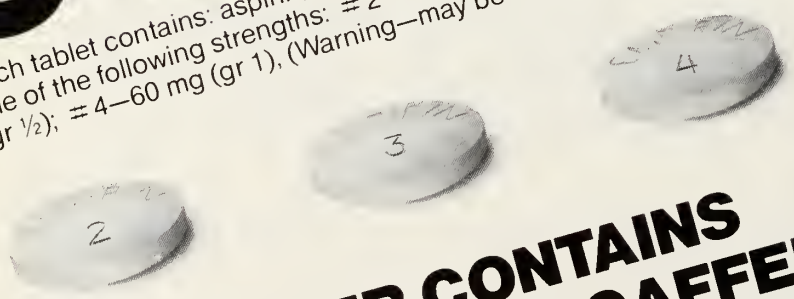
C CODEINE

Each tablet contains: aspirin, 325 mg; plus codeine phosphate in one of the following strengths: ⌀2—15 mg (gr ¼); ⌀3—30 mg (gr ½); ⌀4—60 mg (gr 1), (Warning—may be habit-forming)



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July 1980
Volume 63, Number 7

Rhode Island Medical Journal

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ngle Copies $1.00-Subscriptions $10.00 per year (Members of the Rhode Island Medical Society, $5.00 annually), Second Class postage at Providence, Rhode Island
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An added complication... in the treatment of bacterial bronchitis*

Increasing incidence of ampicillin resistance in Haemophilus influenzae
Ampicillin Resistant Haemophilus influenzae
H. influenzae
S. pneumoniae

Brief Summary.
Consult the package literature for prescribing information.

Indications and Usage: Ceclor® (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae (Diplococcus pneumoniae)*, *Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci)

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor

Contraindication: Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS TO BOTH DRUG CLASSES (INCLUDING ANAPHYLAXIS AFTER PARENTERAL USE).

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Precautions: If an allergic reaction to cefaclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids

Prolonged use of cefaclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs test may be due to the drug.

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such a condition, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

Usage in Pregnancy—Although no teratogenic or antifertility effects were seen in reproduction studies in mice and rats receiving up to 12 times the maximum human dose or in ferrets given three times the maximum human dose, the safety of this drug for use in human pregnancy has not been established. The benefits of the drug in pregnant women should be weighed against a possible risk to the fetus.

Usage in Infancy—Safety of this product for use in infants less than one month of age has not been established.

Adverse Reactions: In clinical studies in 1493 patients, adverse effects considered related to cefaclor therapy were uncommon and are listed below.

Gastrointestinal symptoms occurred in about 2.5 percent of patients and included diarrhea (1 in 70) and nausea and vomiting (1 in 90).

Hypersensitivity reactions were reported in about 1.5 percent of patients and included morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs tests each occurred in less than 1 in 200 patients.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain—Transitory abnormalities in clinical laboratory tests results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic—Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40)

Renal—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200) [070379R]

Some ampicillin-resistant strains of Haemophilus influenzae—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Ceclor.[1-6]

In clinical trials, patients with bacterial bronchitis due to susceptible strains of Streptococcus pneumoniae, H. influenzae, S. pyogenes (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Ceclor.[7]

Ceclor®
cefaclor
Pulvules®, 250 and 500 mg

* Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.[8]

Note: Ceclor® (cefaclor) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

References
1. Antimicrob. Agents Chemother., *8*:91, 1975
2. Antimicrob. Agents Chemother., *11*:470, 1977
3. Antimicrob. Agents Chemother., *13*:584, 1978
4. Antimicrob. Agents Chemother., *12*:490, 1977
5. Current Chemotherapy (edited by W. Siegenthaler and R. Luthy), II: 880. Washington, D.C., American Society for Microbiology, 1978
6. Antimicrob. Agents Chemother., *13*:861, 1978
7. Data on file, Eli Lilly and Company
8. Principles and Practice of Infectious Diseases (edited by G.L. Mandell, R.G. Douglas, Jr., and J.E. Bennett), p. 487. New York, John Wiley & Sons, 1979

Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285

Eli Lilly Industries, Inc.
Carolina, Puerto Rico 00630

000482

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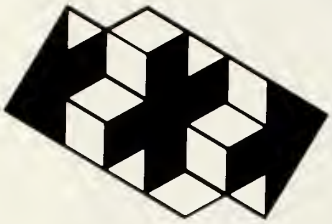
NEWSLETTER

COVER

Photo reprinted from Emergency Medicine, March 1976, with the permission of the publisher. The scene is the operating room of the Maryland Institute for Emergency Medicine. The patient was admitted following an automobile accident, and has been moved into the operating room by the whole emergency team for "one-step" surgery, a minilaparotomy.



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Rhode Island Medical Society

July 1980

Newsletter

Peter L. Mathieu, Jr., MD, Editor
Karen Challberg, Associate Editor

RIMS Supports Providence "Magnet" Program

Betty B. Mathieu, MD
Daniel Moore, Jr., MD
Bennie Fleming, RN

In 1978 the Providence School Department embarked upon a new innovative program for its three high schools, in which special purpose courses are integrated with the regular high school curricula by the "Magnet School Concept". One of the "magnets" is health and science, and Mount Pleasant High School was chosen as the Health and Science Careers Magnet School.

Students are selected to participate in the program on the basis of an interest or motivation toward a health/science career. The school's purpose is to provide a special interest program for those students which will enable them to make sound informed career choices in health and science related areas.

Special curricula have been devised and are constantly being critiqued and modified. Students are involved in a full academic program. Four hours of each day are spent in basic academic subjects. Two hours are spent in the magnet courses. Students are required to take basic science, biology, and chemistry, whether they are in the college preparatory program or the non-college program. The program offers a combination of traditional and health-oriented courses. The curricula are geared to various levels, to educate an orderly or medical secretary, a dermatologist or neurosurgeon. The curricula for the latter two include histology, physiology and advanced mathematics.

In March of 1979 the program became affiliated with the Brown University Medical School. Students go to the Brown campus for lectures and Brown faculty come to Mount Pleasant. Dean Richard Goss of Brown was responsible for the initiation of this arrangement. Dr. Sumner Zacks, Chief Pathologist/Miriam Hospital and member of the Brown faculty, serves as the liaison from Brown and works closely with the Assistant Principal in charge of the Health/Science Magnet. This affiliation also assists the school in securing student job placements in hospitals and health agencies.

There is an Advisory Board of fifteen members with representation from a cross section of health care organizations and agencies. Betty B. Mathieu, MD serves as the representative from the Rhode Island Medical Society and has been a member since the board was established. It is a "working board" and its members have made invaluable contributions in many areas.

RIMS • Membership Count • RIMS May 1980

Active Members	1127
Associate	5
Residents	8
Students	2
Military	2
Exempt	187
Age — 95	
Disability — 8	
Illness — 7	
Retired — 76	
Clergy — 1	
Total	1331
Total AMA Members	747

Many years before Rhode Island began its experiment, Baylor University in Houston, Texas had already founded in 1972 the High School for Health Professions, which is now recognized as the best in the country. This school was the "brain child", not of the Houston Independent School District, but of Joseph Merrill, MD, then Baylor's Executive Vice President, Michael E. DeBakey, MD, Baylor's President, and Robert Toush, EdD, Director of Allied Health Training Programs. The following telegram was sent to Dr. Garner, Superintendent of the Houston Independent School District: "Dr. Joseph M. Merrill has asked me to inform you that Baylor College of Medicine wants to start a high school health curriculum, jointly planned and operated by Baylor and the Houston Independent School District for 30 students by August 23, 1972."

In October, 1979 Mrs. Bennie Y. Fleming from Classical High School was appointed by the Providence School Department to coordinate the Mount Pleasant Program. She was the Head of the Science Department at Classical High School and director of the Laboratory Education Advancement Program (LEAP) of the Brown University Medical School. Mrs. Fleming holds academic degrees and is also an RN. A devoted and dedicated staff of four teachers, one of whom is an RN, formed the core faculty. They worked tirelessly to develop a curriculum, and have continued to critique and develop it. Much of the program's success derives from this group's cooperative efforts with Mrs. Fleming, and from the support and enthusiasm of Mount Pleasant High School principal, Charles Burke.

(continued)

"Magnet" Program (continued)

Shortly after being appointed, Mrs. Fleming went to Houston to see the operation of Baylor's High School for Health Professions, and continues to make yearly visits to the school. She has conferred with Dr. Roush, Principal Weston, and has spoken to Dr. DeBakey.

It was Mrs. Fleming's idea to seek an affiliation with Brown University. She approached Dr. Howard Swearer, who was very receptive to the idea, and thus the groundwork was laid for the affiliation, supervised by Mr. Levi Adams, Associate Vice President, Division of Biology and Medicine.

Developing a program of this magnitude is not an easy task and needs the cooperation and support of the total medical community within an area. Miriam, Roger Williams, Women and Infants and the Veterans Administration Hospitals, since the program's inception, have been very supportive of it, and now are committed within the junior and senior internship programs. In addition, the Providence Visiting Nurses Association, Bannister House, American Red Cross, Rhode Island State Laboratories, and Providence Community Health Centers also have made commitments within the program. Junior year students will spend 4 hours weekly for 12 weeks in a community based health facility. Senior year students will spend 3 hours 4 days a week throughout the academic year interning in the community. All students will be carefully selected and supervised.

We believe that this venture, once our growing pains are over, will become a source of pride for the Providence community.

It is essential now for the Rhode Island Medical Society to support this innovative program. We need commitment from individual physicians practicing in the Providence community for students to be placed in their offices by Mrs. Fleming, the coordinator. Students will work with the physician's office staff to gain experience of office functions, and supply services to the physician as he/she requires. An inappropriate placement for the student or the physician would mean immediate termination of the student/physician relationship. Physicians interested in participating in this program should contact Dr. Daniel Moore, President, Providence Medical Association, 106 Francis Street, Providence, Rhode Island, or call 331-3207 or 421-6348.

JUA Update

At a recent meeting of the Board of Directors of the Joint Underwriting Association (JUA), it was voted to seek a raise in rates for the upcoming year by 25.3%. This was based on actuarial data collected by Mr. Thomas Hermes, actuary for the association.

As part of its overall effort to monitor and control costs associated with the delivery of health care, the Rhode Island Medical Society will again this year study the JUA data and develop its own recommendations for rate change, if any, for next year. Mr. Robert Sturgis, from the actuarial firm of Tillinghast, Nelson & Warren has been hired by the Society to research and analyze data to this end. Tillinghast, Nelson & Warren is located outside of Hartford, Connecticut.

Council Briefs

Meeting June 9, 1980
Peter L. Mathieu, Jr., MD, Presiding

- Appointed Charles L. Hill, MD to the position of Executive Vice President of the Rhode Island Medical Society.
- Voted to table the report of the Management Committee. The report will be reconsidered at the Council meeting in August.
- Voted to accept Dr. Melvin Hoffman's revisions of Mediation Committee procedures for obtaining physician participation and cooperation in dealing with complaints, subject to review by legal counsel.
- Voted to accept requests for representation in the Rhode Island Medical Society by the Rhode Island Neurological Society and the Rhode Island Thoracic and Cardiovascular Society pending review by Dr. Charles L. Hill.
- Voted that Past Presidents will remain members of the Council (non-voting after five years) and House of Delegates (non-voting) as long as they are members of the Rhode Island Medical Society.
- Voted to contribute $500 to the 15th Annual Medical Aspects of Sports program to be held July 17-18, 1980 at the University of Rhode Island.
- Voted to endorse the Health/Science Magnet Program at Mt. Pleasant High School.
- Voted to allocate $200 to Dr. Charles Shoemaker, Chairman, Hi-Tech, Hi-Touch Committee for consultation services to determine the feasibility of employing computer technology for various Society operations.
- Heard the Report of the Treasurer, Dr. Erminio Cardi.

Council Prayer*

Oh Lord, aware that there are a variety of skills, but constantly searching for the *Competence* in all of us, this administration will stress the *Competence* in each of us.

We need to define the goals of the Rhode Island Medical Society to help us to arrive at *Commitment*. Real *Commitment* will come as we travel this long journey. I see much evidence of *Commitment* in our Society. I am not sure at this time that we have balanced *Commitment*.

In the order of creation every one of us has a special task to take up. This is our *Calling*. The administration must pay attention to the inner motivations that helped all of us to success, understand what is most meaningful to us, relate *Calling* with *Commitment*, to fulfill ourselves *Competently*. We must forget about the "market" and we ask You, Oh Lord, to give us courage to pursue the three *Cs* and we shall have success.

I pray for this Council not conventional success, but for this Council and this administration the three *Cs*, a legacy to those who follow in this journey.

*Delivered by Peter L. Mathieu, Jr., MD at the meeting of the Council of the Rhode Island Medical Society, June 9, 1980.

Interview of the Month:
Stan Aronson, MD, Dean

Stan Aronson was a schoolteacher of biology when he decided to volunteer for the armed services, and as usual after such decisions things are never again quite the same. He spent four years in the service, then entered medical school, graduating three years after the end of World War II.

Post graduation, career-launching years for him were of the kind experienced by young doctors everywhere with more to do than there could possibly be hours in the day for. Following residency training he did research for the National Foundation for Infantile Paralysis in New York City, taught at Columbia University, developed a research service for the care of children with degenerative diseases at the Jewish Chronic Disease Hospital of Brooklyn, was Professor of Pathology at the State University of New York (SUNY Downstate), Director of Laboratories at King's County Hospital in New York City, and Assistant Dean of the Medical School at SUNY. Since then he has held posts in universities around the world, teaching at institutions including Mexico City, Dalhousie, Cambridge, and Yale.

He had already authored 4 textbooks and over 250 scientific articles, when he came to Brown University as the Chairman of the Department of Pathology in 1970, and had been here only one year when the idea for a Brown University Program in Medicine had begun to take form. The program was accredited in 1972 and in 1973, with Dr. Aronson appointed Dean of Medicine, it was in full operation. In 1975 the first class graduated, and with the sixth class to graduate in 1980 there are now a total of 364 Brown University Program in Medicine alumni.

These days the Dean is in Washington a lot of the time. He is (or was) a consultant to four presidential commissions, including the colloborative perinatal study group, the Commission on Huntington's Disease, and the Commission on Multiple Sclerosis. Multiple sclerosis is one of Dr. Aronson's keenest interests, and he is presently chairman of research of the National Multiple Sclerosis Society. He is also actively involved in the Liaison Committee on Medical Education (LCME), which accredits the nation's medical colleges, made up of representatives of the American Association of Medical Colleges (AAMC) and the American Medical Association (AMA).

Last Year the ex-schoolteacher, doctor, professor, author and educator made out an application form to become a student again. His application was accepted. In September he will begin classes at the Harvard School of Public Health, specializing in epidemiology.

Why? "I think we have to challenge ourselves to start all over again sometimes. It makes life more meaningful."

Why epidemiology? "The medical, genetic and other forces which combine to form susceptibilities in one individual or group of individuals and not in others are exciting mysteries to me. Medicine looks at one person at a time and solves problems as they arise, public health looks at groups and tries to prevent and eliminate problems by a preventive course, but of course the two perspectives are intimately connected and mutually supporting."

Why Harvard School of Public Health? "It's one of the best schools of its kind in the country with great teachers and carefully selected students. I'm a little scared!"

What will he look like commuting to school? A tee-shirt, a windbreaker, corduroys, and moccasins. How will he get there? By bus and subway or trolley, or maybe jog!

Support "Kidsafe"

The new Rhode Island law, pertaining to "child passenger restraint systems", effective July 1, 1980, was introduced by Representative Henry J. Connors of East Providence. Rhode Island is the second state in the nation to enact a mandatory child restraint law; Tennessee was the first. The law states, "any person transporting a child three years of age or under in the front seat of a motor vehicle operated on the roadways, streets or highways of this state will provide for the protection of the child and properly use a child passenger restraint system approved by the United States Department of Transportation under Federal Standard 213."

Pediatricians and other physicians can encourage compliance by reminding parents of the facts: disfiguration, brain damage, head and neck damage, and epilepsy are some of the most common permanent handicaps suffered by children as a result of automobile accidents; studies show incidence of disabling injuries could have been reduced (716 to 238) by proper use of seat belts.

District Bites . . .

Bristol County Medical Society

Bristol County Medical Society held its annual fete at the Rhode Island Country Club in Barrington on May 21, 1980, with a free bar and swordfish dinner, and about 25 doctors and their wives in attendance.

During a short business meeting dues were raised from $30 to $40 per year, and the following new officers were installed:

Alexander N. Arvanitidis, MD, President
David Newhall, MD, Secretary
Thomas Drew, MD, Treasurer
Marshall Taylor, MD, Councillor
John M. DeMicco, MD, Delegate

Newport County Medical Society

On May 29, 1980 the Newport County Medical Society held their spring dinner meeting at the Canfield House in Newport. At a short business meeting after the dinner, President Peter D.T. Clarisse, MD brought members up-to-date on "Appropriateness Reviews" planned by the Rhode Island Department of Health. Then John Carr, MD presented the recommendation of the nominating committee to break precedent and re-elect all of the incumbent officers:

Peter D.T. Clarisse, MD, President
Lewis Arnow, MD, Vice President
Stephen Grimes, MD, Secretary
Eli Cohen, MD, Treasurer
Edward Singsen, MD, Delegate
Charles Shoemaker, MD, Delegate
Thomas Cahill, MD, Delegate
Peter D.T. Clarisse, MD, Councillor
(For at least the ensuing two years the posts of President and Councillor will be combined.)

The remainder of the evening was devoted to entertainment by Howard Marcus, MD playing a selection of classical piano pieces, with accompaniments by soloist Mary Day singing several short pieces of German Lieder.

Pawtucket Medical Association

The annual installation of officers dinner meeting of the Pawtucket Medical Association was held at the Pawtucket Country Club on June 11, 1980. Dr. Benjamin R. Healey served as coordinator for the afternoon golf tournament. Top golf honors were won by Dr. Joseph C. Kambe.

Retiring president, Dr. David R. Hallmann was master of ceremonies. Ron Scott's Orchestra serenaded the 135 doctors, their wives and guests. Drs. Constantine G. Demopulos, Byron R. Quinn and Thomas J. Martin were a riot singing the nifty songs of the fifties while impersonating the Andrews Sisters.

Newly elected officers are:

Richard G. Bertini, MD, President
Royal C. Hudson, Jr., MD, Vice President/Secretary
Khalil Shekarchi, MD, Treasurer

The two immediate past presidents, Drs. Paul B. Metcalf, Jr. and David R. Hallmann, will serve on the Executive Committee.

Rhode Island Medical Society County Auxiliary Officers, 1980-1981

Courtesy of Marion Hager

There are no elected Rhode Island state medical society auxiliary officers. The county groups function independently and in coordination with each other in projects and meetings. Kent County Medical Society Auxiliary will be responsible for the Annual Meeting of all counties and for coordinating in 1980-1981. County officers for the year are:

Kent County Medical Society Auxiliary
President: Mrs. William Van Haaren (Jane) 399 Algonquin Dr. Warwick 02888 463-8408
Vice President: Mrs. Jacobo Fijman (Alison) P O Box 157 Ashaway 02804 377-4015
Secretary: Mrs. John Hayes (Charlotte) 145 Bow St. East Greenwich 02818 884-7058
Treasurer: Mrs. David Mayer (Sandra) 416 Gauvin Dr. Warwick 02886 822-2771

Newport County Medical Society Auxiliary
President: Mrs. John R. Fox (Joan) "Beechbound" Harrison Ave. Newport 02840 846-5009
Vice President: Mrs. Stephen Grimes (Jeanne) 48 Diane Ave. Portsmouth 02871 846-2947
Secretary: Mrs. Anthony Carrellas (Mary Lou) 24 Dudley Ave. Newport 02840 849-3923
Treasurer: Mrs. Richard Knowles (Colleen) Pen Craig, Harrison Ave. Newport 02840 846-0431

Providence Medical Association Auxiliary
President: Mrs. Alex Arvanitidis (Patricia) 130 Ferry Lane Barrington 02915 245-2080
Vice President: Mrs. Arun K. Singh (Barbara) 38 Beachmont Ave. Cranston 02905 467-4994 After Aug. 303 Laurel Ave. Providence 02906
Secretary: Mrs. John J. O'Brien 33 Varnum Dr. East Greenwich 02818 884-3690
Treasurer: Mrs. Richard D'Amico (Marie) 233 Northbridge Ave. Warwick 02886 739-2182

Woonsocket District Medical Society Auxiliary
President: Mrs. Jose Galardy (Jean) 521 South Main St. Woonsocket 02895 766-5152
Vice President: Mrs. Leonard Staudinger (Pat) 542 Prospect St. Woonsocket 02895 766-1118
Secretary: Mrs. Vincent DeCesaris (Pat) 7 Kirkbrae Dr. Lincoln 02865 333-1924
Treasurer: Mrs. James P. O'Brien (Doris) 229 Woodland Rd. Woonsocket 02895 762-3301

Pawtucket Medical Association Auxiliary
inactive at present
AMA-ERF: For all auxiliaries Mrs. Daniel Calenda (Belle) 296 Taber Ave. Providence 02906 272-2352
Previous Past Presidents acting as Advisors:
Mrs. Daniel Calenda (as above)
Mrs. John J. Cunningham (Bert) 18 Anawan Rd. Pawtucket 02861 722-6659
Mrs. Thomas Egan (Charlotte) 1550 Worcester Rd. Framingham, Mass. 01701 (617) 879-1019
Mrs. Herbert F. Hager (Marion) 42 Kensington Rd. Edgewood 02905 781-9192

Administrative Reports . . . Weekly Meetings with Staff

Wednesday, May 21, 1980 . . . Rhode Island Department of Health request for comments on CON application from Rhode Island Hospital to expand emergency room facilities was referred to Charles E. Millard, MD . . . received resignation of Stephen J. Hoye, MD from the Management Committee, appointed Erminio Cardi and Charles E. Millard, MDs to this committee . . . request for subjects for next year's Fiske Fund Essay Competition . . . established Blue Cross/Blue Shield Liaison Committee, appointed Paul B. Metcalf, Jr., MD to be chairman . . . decided to limit future expenditures to HARI . . . received report of AMA Council on Education, will seek comments from John J. Cunningham and Joseph D. DiMase, MDs.

Wednesday, May 28, 1980 . . . received letter of regret from Anthony F. Merlino, MD that he is unable to accept chairmanship of the Committee on Peer Review . . . discussed combining Mediation and Peer Review Committee functions . . . decided to employ Robert Sturgis, Vice President of Tillinghast, Nelson and Warren to evaluate this year's proposed JUA rate increases . . . discussed AMA sponsored practice management and negotiations workshops as ideas for the next annual meeting . . . AMA Report on EDP Equipment Survey of State Medical Societies was referred to Charles P. Shoemaker, Jr., MD, chairman of the Hi-Tech Hi-Touch Committee . . . received notice that the Cooper property is located in a zone which does not permit office use, and decided to seek a variance from the zoning ordinance.

Wednesday, June 4, 1980 . . . discussed the Mt. Pleasant High School Health/Science Magnet Program and agreed to encourage members to support it . . . discussed the JUA Board of Directors' decision on a proposed rate filing . . . recommended a meeting between Kenneth Liffmann, MD and members of the Committee on Self-Insurance to evaluate JUA actions . . . reviewed actions of the Committee on the Delivery of Medical Care regarding the Rhode Island Department of Health Work Program for Appropriateness Reviews and decided to inform district and specialty society presidents of new developments.

Wednesday, June 11, 1980 . . . reviewed actions of the meeting of the Council held June 9, 1980 . . . discussed need for more cooperation between executive officers and committee chairmen . . . called for a meeting of the Cooper Property Committee to discuss the possibility of obtaining a mortgage on this property . . . discussed Dr. Cannon's decision on Fogarty Hospital's application to establish an ambulatory care facility in Burrillville . . . Paul B. Metcalf, Jr., will research regulations pertaining to this decision for next meeting . . . will invite Department of Health representatives for an informational session on the situation.

Medical Meetings

JULY 1980

		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	31		

AUGUST 1980

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10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31						

SEPTEMBER 1980

	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30				

July

17-18 15th Annual Post-Graduate Conference on Medical Aspects of Sports; URI, Kingston, Rhode Island
19 Meeting of State Medical Association Presidents; Marriott Hotel, Chicago
20-24 House of Delegates of AMA; Marriott Hotel, Chicago
30 SHPDA Liaison with PSRO, regular meeting; Cannon Building, Providence

August

18 Rhode Island Medical Society Council; regular meeting; RIMS Building

September

8 Staff Physicians Association of Rhode Island; regular meeting
22-24 Irish-American Pediatric Society; Cork, Ireland
Rhode Island Medical Society House of Delegates; regular meeting; RIMS Building

Drug Information Service at RWGH

Drug Information Service (DIS), an extension of the University of Rhode Island College of Pharmacy located at Roger Williams General Hospital in Providence, supplies a wide range of drug information to health care professionals throughout the state. The service maintains a basic library of periodicals, primary references, textbooks of pharmacology and medicine, and the Iowa Drug Information Service (IDIS). The IDIS provides drug and disease state indices as well as the original articles on microfiche from over one hundred fifty journals dating from 1966 to the present.

Telephone number to DIS is 456-2260.

The service is open Monday through Friday, 8 am to 4 pm. Calls after office hours are taken by the pharmacy staff at the hospital.

RIMS Council and House of Delegates Meeting Dates: 1980-1981

Council	
June 9, 1980	Monday, 6 pm
August 18, 1980	Monday, 6 pm
October 20, 1980	Monday, 6 pm
December 1, 1980	Monday, 6 pm
February 9, 1981	Monday, 6 pm
April 13, 1981	Monday, 6 pm
House of Delegates*	
September 24, 1980	Wednesday, 2 pm
January 21, 1981	Wednesday, 2 pm
March 18, 1981	Wednesday, 2 pm
Annual Meeting	May 27, 1981

*All members are invited to attend the meetings of the House of Delegates.

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Oches and Pains . . .

• Indiana's Medical Malpractice Act, one of the first in the nation, was ruled constitutional by the state Supreme Court. Portions of the legislation have been used by other states in drafting professional liability acts. Indiana State Medical Association backed the legislation when it was enacted in 1975 and supported it throughout the court challenge. Under the law physicians' premiums support a malpractice fund administered by the state. There is a $500,000 limit on awards, and the liability of physicians who qualify under the act is limited to $100,000. The legislation provides for pretrial screening of claims. It includes a two-year statute of limitations, except for persons under six, who have until their eighth birthday to file claims.

• Sources of consumer information and assistance are explained in a new booklet titled *Consumer's Resource Handbook*, available free of charge from the Consumer Information Center, Department 532 G, Pueblo, Colorado 81009. The booklet contains information for consumers of health services.

• In a recent decision, the Supreme Court of Mississippi ruled that a statutory provision required a certain number of members of the state board of health to be ". . . regular qualified physicians of the state and members of the state medical association . . . nominated to the governor by the state medical association . . . [appointed by] the governor . . . [and] confirmed by the senate" is constitutional.

• The AMA has recently developed model state legislation to provide for the disposal of medical nuclear waste materials and other low-level radioactive waste materials. Copies of the model bill, approved by the AMA Board of Trustees at its meeting earlier this month, are available upon request. To obtain a copy, write to: American Medical Association, Department of State Legislation, 535 North Dearborn Street, Chicago, Illinois 60610.

• There presently are six states whose investigational New Drug applications for marijuana therapeutic research have been approved by the Federal Food and Drug Administration (FDA): Florida, Illinois, Louisiana, Michigan, New Mexico, and Washington. These are among the twenty-one states which have enacted legislation authorizing research on the therapeutic use of marijuana, the use of marijuana for therapeutic purposes, or both.

• A resolution to change bylaws to permit unified membership at the county, state, and AMA levels was passed by a vote of 142 to 83 at the annual meeting of the Medical Society of New Jersey. The resolution was introduced by the Bergen County Medical Society, which has championed it for five years. A two-thirds vote to change the bylaws must occur at next year's annual meeting for final ratification of the resolution.

• The May 1980 editions of the *Opportunity Placement Register* and the *Physician Placement Register* are now available. *Opportunity* lists current openings along with such information as date of availability and beginning salary. *Placement* lists physicians seeking new practices. Both registers are published quarterly. Copies and registration information are available from Physicians' Placement Service, AMA Headquarters.

Rhode Island Medical Society Appointed Committees, 1980-1981**

Aging Committee

*Johannes Virks, MD, Chairman
*Fred Barnes, MD, Vice-Chairman
*Henry Izeman, MD, Secretary
*Sarah Saklad, MD
Agnes Somlo, MD
*P. Joseph Pesare, MD
*Joseph McWilliams, MD
*Mark Yessian, MD
*A. Lloyd Lagerquist, MD
*Hubert Holdsworth, MD
*Perry Garber, MD
*Michael S. Barrett, MD
*Elmer Gale, MD
*Robert Hopkins, MD
*Stephen Richman, MD
*Richard Kraemer, MD
Oscar Liu, MD
*Alfredo Cassiet, MD
*Carl Granger, MD
Paul Alexander, MD
David Greer, MD
*Elihu Wing, MD
*Max Fershtman, MD
Vera Fish, MD
*John Lury, MD
*Ron Cavanagh, MD
*Ezra Sharp, MD
*Irving Beck, MD
Auxiliary Representative:
Mrs. Jose Galardy

Alcohol and Substance Abuse Committee

*John E. Farley, Jr., MD, Chairman
*David Lewis, MD, Vice-Chairman
*William Mauran, MD, Secretary
Roswell Johnson, MD
*Edmund Billings, MD
Charles Charon, MD
Leo Cok, MD
Joseph DiMase, MD
John Carr, MD
*John Murphy, MD
*Nathan Sonkin, MD
Richard McDermott, MD
Demmie Mayfield, MD
*Paul E. Poirier, MD
*Charles Goodman, MD
Neida Ogden, MD
*Pietro Russo, MD
William Braden, MD
*Ezra Sharp, MD
*Paul Blackmore, MD
LeClair Bissell, MD
*Dante Ramos, MD
*Collette Cunningham, MD
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Bruno Franek, MD
*Gilbert Altongy, MD
*Paul Poirier, MD
*Robert Drew, MD
Auxiliary Representative:
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Auxiliary Committee

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Vice-Chairman
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*Ronald P. Zinno, MD
Alexander Arvanitidis, MD
Violet Manansala, MD
Tadeusz Gotlib, MD
*Elie J. Cohen, MD
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Vice-Chairman
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Joseph Chazan, MD
Marvin Chernow, MD
*Israel Diamond, MD
*Joseph Hansagi, MD
*Herbert Lichtman, MD
*William Thompson, MD
Augustine Colella, MD
*John Osenkowski, MD
Peter Smith, MD
Nora Spens, MD
Mary Colbert, MD
*Sheldon Kaplan, MD
Richard Rosen, MD
*John Lawlor, MD
*Renee Vogel, MD
Richard D'Amico, MD
*Betty Aronson, MD
Robert Knisley, MD
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*Peter L. Mathieu, Jr., MD,
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Secretary
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*Joseph E. Caruolo, MD
*John J. Cunningham, MD
*Richard R. Dyer, MD
*Edmund T. Hackman, MD
*Herbert F. Hager, MD
*Paul J. M. Healey, MD
*Melvin D. Hoffman, MD
Kenneth E. Liffmann, MD
*Leonard S. Staudinger, MD
*John J. Walsh, Jr, MD
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William Murdocco, MD
*Charles Ashworth, MD
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*Henry McDuff, MD
John Lathrop, MD
Denise Moonay, MD
*Bruce Raymond, MD
*Paul Botelho, MD
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Banice Webber, MD
*J. Douglas Nisbet, MD
*Harry Iannotti, MD
Frank D'Alessandro, MD
Anthony Testa, MD
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James F. Brown, MD
*John E. Farley, Jr, MD
*Frank Giunta, MD
Herman B. Marks, MD
William McDermott, MD
J. Brian May, MD

*Member of the American Medical Association

**A student and resident will be added to each committee upon joining the Society.

Angelo D'Agostino, MD has been invited to be the Washington, DC liaison with the Rhode Island Medical Society.

Robert Lord, MD
Gunnar Nirk, MD
Irene Hornik, MD
*Eric Denhoff, MD
George Taft, MD
*H. Raymond McKendall, MD
Gerald Faich, MD
*Domenic Cetronio, MD
*Hugo Taussig, MD
Manning Panero, MD
*John Moran, MD
*Raymond Waggoner, MD
Neida Ogden, MD
*Betty Aronson, MD
Auxiliary Representative:
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*David Hallmann, MD, Chairman
Erminio Cardi, MD, Vice Chairman
*Herbert Hager, MD, Secretary
*Charles L. Hill, MD
*Peter L. Mathieu, Jr, MD
*Charles E. Millard, MD
*Peter D. T. Clarisse, MD
Auxiliary Representative:
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Delivery of Medical Care Committee

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Vice Chairman
*Royal C. Hudson, MD, Secretary
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*Fred Eckel, MD
*Charles Hall, MD
Patrick Levesque, MD
Stanley Simon, MD
Robert D. Coli, MD
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*Bernard Berstein, MD
David Nichols, MD
*John Moran, MD
*Richard Land, MD
Robert Rosin, MD
*Stephen Frater, MD
*Alban LeBlanc, MD
*Richard Judkins, MD
*Sheldon Kaplan, MD
David Newhall, MD
Boyd P. King, MD
*Robert Riemer, MD
*Slobodan Gajic, MD
*Joseph Peltier, MD
*Elihu Wing, MD
*Robert Indeglia, MD
*Antonio Capone, MD
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*Francis Lamb, MD
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*Richard Land, MD
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Stanley Aronson, MD
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*Eric Denhoff, MD
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*Irving Beck, MD
Albert Most, MD
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*Michael Scala, MD
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*Leo Stern, MD
Charles MacDonald, MD
Jaroslaw Koropey, MD
Earle Cohen, MD
Roger Fontaine, MD
*Conrad Wesselhoeft, MD
*Thomas Vest, MD
*Naeem Siddiqui, MD
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Societies
Presidents (Chairman) Specialty
Societies
Presidents Hospital Staffs
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Hi-Tech Hi-Touch Committee

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Vice Chairman
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*David Hallmann, MD
*Peter L. Mathieu, Jr., MD
David Greer, MD
*Robert Kinder, MD
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*Elliott Perlman, MD
*Milton W. Hamolsky, MD
*Paul B. Metcalf, Jr., MD
*William Klutz, MD
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Christian Herrera, MD
Paul Alexander, MD
*Robert E. DeForrest, MD
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Baruh Motola, MD
Joseph Donahue, MD
Louis Hafken, MD
*Charles Staunton, MD
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*Robert Drew, MD

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*Anthony Merlino, MD
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*H. Gerald Rock, MD
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Erminio Cardi, MD
*John Hand, MD
Roger Ashley, MD
James Murdocco, MD
Edwin Singsen, MD
*Austin White, MD
*Alton F. Curran, MD
*Milton W. Hamolsky, MD
*Francis B. Sargent, MD
*Norman Peters, MD
*Tom Morgan, MD
*Elie Cohen, MD
*John Coughlin, MD
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*Henry Whited, MD
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*Charles L. Hill, MD
*Joseph E. Caruolo, MD
*Frank Sullivan, MD
*Richard Sexton, MD
Pierre Galletti, MD
Stanley Aronson, MD
John P. Wood, MD
*Herbert Lichtman, MD
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*J. Douglas Nisbet, MD, Secretary
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*George Anderson, MD
Kenneth J. Beezer, MD

John Carey, MD
Herbert Ebner, MD
Julius Migliori, MD
Yusef Barcohana, MD
John Evrard, MD
William MacDonald, MD
Benjamin Vogel, MD
Kenneth Beezer, MD
Clinton Potter, MD
Alvin Gendreau, MD
Don B. Singer, MD
Bernard Berstein, MD
Yilmaz Durudogan, MD
John Ferris, MD
John P. Wood, MD
Adelino Santa Teresa, MD
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Marshall Taylor, MD
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William Barnard, MD
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*Ralph Pike, MD
*Paul Welch, MD
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*A. Louis Mariorenzi, MD
Raymond Moffitt, MD
*Karl Stephens, MD
*Richard Murphy, MD
Ernest Lowe, Jr., MD
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*Robert Riemer, MD
William Levin, MD
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*James Herndon, MD
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Carlos Nieto, MD
Guy Geffroy, MD
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*Jacob Schinazi, MD
Jan Dudek, MD
Sany Abraham, MD
*Richard Kraemer, MD
*Daniel B. Reardon, MD
*George Jacewicz, MD
*Mary D. Lekas, MD
*Daniel Moore, Jr., MD
Saklad Associates
Rhode Island Association of Medical Assistants: Emma Cohen
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Vice Chairman
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*Herbert Hager, MD
*Leonard Staudinger, MD
*John Cunningham, MD
*William Garrahan, MD
*David Hallmann, MD
*Paul Welch, MD
*John Baxter, MD
*Norman Peters, MD
*Collette Cunningham, MD
*Kenneth Knowles, MD
Daniel H. Lederer, MD
*Anthony Merlino, MD
Marshall Taylor, MD
*Robert Hopkins, MD
*Michael Faella, MD
Paul Hudson, MD
James McGrath, MD

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Alberto V. Erfe, MD
Wu-Hsiung Su, MD
Fred Vohr, MD
*Kenneth Knowles, MD
Patricia A. Hyzinski, MD
Thaddeus Gotlib, MD
Auxiliary Representative:
Mrs. N. Chahmirzadi
See additional organizational chart

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*Nathan Epstein, MD,
Vice chairman
*Frank Sullivan, MD, Secretary
*Eufrocino Beltran, MD
Duncan Ross, MD
*Antonio Capone, MD
*Domenic Coppolino, MD
*Charles Goodman, MD
John Ruggiano, MD
*Gabriel Najera, MD
*Gunnar Nirk, MD
*Raymond Waggoner, MD
*Louis Sorrentino, MD
*Henry Izeman, MD
Samuel Hunt, MD
*Joseph Zucker, MD
Max Faintych, MD
*Paul H. Shield, MD
Thomas Greason, MD
Michael Ingall, MD
*Ben Feather, MD
Pasquale Finnelli, MD
Melvyn Johnson, MD
*Ernesto D'Agostino, MD
Auxiliary Representatives:
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Mrs. G. Geffroy

Negotiations Committee

*Augustine McNamee, MD,
Chairman
*Melvin D. Hoffman, MD,
Vice Chairman
Erminio Cardi, MD, Secretary
Kenneth Nanian, MD
Paul B. Metcalf, MD
*Rajnikant Shah, MD
Oscar Liu, MD
*John Moran, MD
Barbara Roberts, MD
*Carl DeLuca, MD
*Peter L. Mathieu, Jr., MD
*Robert Indeglia, MD
*Thomas Morgan, MD
*John Baxter, MD
*Emilio Monti, MD
Joseph Delfino, MD
Terry McEnany, MD
Alexander Jaworski, MD
*Richard D. Frary, MD
Auxiliary Representative:
Mrs. R. Knowles

Nursing Committee

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*Betty Mathieu, MD,
Vice Chairman
Jorge Alonso, MD, Secretary
*Maurice Adelman, MD
*John Dillon, MD
*Asdrubal DeCarvalho, MD
*Robert Riemer, MD
*Jeannette Vidal, MD
*Frank DeLuca, MD
*George Taft, MD
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PRESIDENT'S CORNER

Health Care Finance: A Macro-Economic Look Part I

The cost of health care in this country has aroused much concern in the past fifteen years because of the increasing share of the Gross National Product (GNP) devoted to it. For instance, in 1929 health care required only 3.5 per cent of the GNP and the per capita expenditure for it was $29.16, in 1950 4.5 per cent of the GNP was required with a per capita expenditure of $78.35, and in 1966 5.8 per cent was required with a per capita expenditure of $211.56. Ten years later in 1976, 8.6 per cent of the GNP was spent for health care with a per capita expenditure of $637.97. In 1978 9 per cent, and in 1980 an estimated 10 per cent of the GNP will be spent for health care. In the same period requirements for food, beverage, and tobacco decreased from 30 to 22 per cent of the GNP, clothing decreased from 12 per cent to 8 per cent, while housing increased only from 11 to 15 per cent.

A comparison of percentages of GNP for health care in different countries shows that in 1971 in the United States 7.5 per cent of the GNP was used for this purpose; in the Netherlands 7.3 per cent; in Sweden 7 per cent; in Germany 5.7 per cent; in France 5.6 per cent; and in England only 4.9 per cent. In Massachusetts, where the health care industry is a big business, 12 per cent of its GNP goes for health care.

How the health care dollar is spent is also interesting. In 1950 the cost of hospital care was 30 per cent of the health care dollar, but in 1976 it was 39.8 per cent. In 1950, 22 per cent of the health care dollar went to the physician, but by 1976 the percentage had dropped to 18.9. Dental care took 7.5 per cent of the health care dollar in 1950, but only 6.2 per cent in 1976; nursing homes, 1.7 per cent of the health care dollar in 1950, 7.6 per cent in 1976. In 1950, only 2 per cent of health spending was for prepayment plans and administration costs, but in 1976 this had increased to 5.2 per cent. In 1950, research took 8 per cent of the health care dollar, but in 1976 only 2.4 per cent. Three per cent of the health care spending was for public health in 1950, and 2.4 per cent in 1976. Drugs cost 13.3 per cent of the health care dollar in 1950, and 8 per cent in 1976. Environmental preventive health care costs are not considered health care expenditures per se.

From 1950 to 1976 inflation increased by 5 per cent. Thus only about half of health care cost increases are explainable by inflation. Forty per cent of health care cost increases resulted from hospital cost increases. This explains why much health care planning and regulation by the federal and local governments is targeted at hospitals. According to figures just released, approximately 62 per cent of hospital budgets are spent for salaries, with the remainder spent on supplies, insurance, depreciation, and miscellaneous items. Breaking down the hospital salary dollar physicians receive 6.4 per cent of it; administrators 3.9 per cent; service workers 23 per cent; and nurses, dieticians, and therapists 16.2 per cent.

A comparison of figures for total health care sums spent in 1950, in 1965 prior to the passage of Medicare-Medicaid legislation, and in 1976 ten years after the institution of Medicare-Medicaid is significant. In 1950 the total cost of health care in the United States was 12 billion dollars. In 1965 the sum had increased to 38 billion dollars, and in 1976 to 140 billion dollars. In 1950, of 12 billion dollars, 3.7 billion went for hospital care, of which 34.2 per cent was paid directly by the patient, 16.5 per cent by private insurance, and 45.7 per cent by the federal government. In 1965, out of 38 billion dollars, 13.1 billion dollars was spent for hospital care, of which 18.5 per cent was paid directly by the

patient, 41.7 per cent by private insurance, and 37.5 per cent by the federal government. In 1976, ten years after the passage of Medicare-Medicaid legislation, 55.4 of 140 billion dollars were used for hospital care. Of this, the patient paid only 8.9 per cent directly, private insurance paid 35.1 per cent, a decrease of 6 per cent from 1976, but the federal government paid 54.9 per cent. Well over half of hospital care costs are paid for by the federal government.

Between 1950 and 1976 the Consumer Price Index (CPI) increased by 2½ times. While drug increases were below CPI levels, and dentist fees increased by 2½ times from 1950 to 1976 (exactly comparable with CPI indications), physicians' fees increased by 2¾ times, and the charge for a hospital semi-private room increased by 4 times.

Why have hospital costs, in particular, increased so much? There is no single answer. Why has the cost of health care increased from 12 billion dollars in 1950 to the estimated 200 billion dollars which will be spent for it in 1980? Is anyone to blame? Is it the health industry itself, particularly hospitals? Is it the health insurance companies? Is it the government? Is it society?

There are many theories why health care costs have been rising so much faster than the rate of inflation. A few of these explanations are summarized below:

1) Martin F. Feldstein of Harvard University notes that both health services and health products have changed, that they are not the same in 1976 or 1980 as they were in 1950, attributing only 25 per cent of the increase in health care costs to an increase in charges, and 75 per cent to an increase in output. The increase in output, according to Feldstein, is the result of the large contribution of private and federal insurance agency funding of so much health care.

2) Professor Harris of the Massachusetts Institute of Technology theorizes that the increase in health care costs has been caused by the nature of the health care organization itself, which harbors many inefficiencies resulting from a split in authority between physicians and administrators.

3) Senator Hart, on the other hand, believes that the problem lies in the abundance of physicians, suggests that in accordance with Roehmer's Law utilization of services increases in proportion to their availability. This is an often heard rather simplistic, explanation. In the past it was thought that the health care industry, like other industries, is affected by the laws of supply and demand, with the result that an increased number of physicians would reduce the cost of their services. And so, more and more students were graduated from the country's medical schools each year; in 1971, the number of new physicians graduated was 8,974; in 1977, the number was 13,607; and there was a steady influx of foreign physicians. As a result, in 1971 there were 166 MDs per one hundred thousand population and by 1977 194. Now, President Jimmie Carter, in an effort to reverse this trend, is proposing the elimination of federal grants to medical students. In Peter Illyich's expression of this theory, the increase in health care costs is "iatrogenic"; "physicians cause illness"; and as a corollary, too much money is spent on private health care, and too little on public-health-type efforts.

4) Robert Claiborne holds a traditional, liberal theory that the "system" is at fault; that the increase in the cost of health care is a conspiracy; and that, if those who run the system could be replaced, the cost of health care could be controlled.

5) The National Commission on Health Care holds the view that the delivery of health care creates an unusual marketplace, far from ideal, in which the improper interplay of forces is responsible for continually increasing costs.

6) Finally, the American Enterprise Institute (AEI), a conservative businessmen's group, holds an eclectic position on the problem; they believe that a large number of factors have contributed to the increase cost of health care.

This has been an overview of some of the facts and theories surrounding high health care costs. The problem is a vexing one. Conclusions are difficult. Discussion of the subject will be continued next month.

Peter L. Mathieu, Jr., MD
President

DEAN'S MESSAGE

The State of Rhode Island Internships, 1980-81

At approximately yearly intervals, this column summarizes the residential and professional backgrounds of those interns newly recruited by the hospitals of this State for service during the academic year beginning each July. These data are compared with similar information assembled during previous years.

One hundred and two men and women were recently selected for internships in internal medicine, family medicine, pediatrics, surgery and obstetrics/gynecology, practically all identified through the complex mechanism of the National Intern and Resident Matching Program, which concludes its efforts in March of each year. The Match-

Table 1. Medical Schools Attended by Interns in the Hospitals of the State of Rhode Island

Region:	1977-78	1978-79	1979-80	1980-81
NEW ENGLAND	(23)	(34)	(27)	(31)
Boston U	3	1	2	2
Brown U	11	13	9	14
U Conn	1	1	2	4
Dartmouth	1		1	2
Harvard U	1	3	1	1
U Mass	2	5	6	5
Tufts	3	2	4	1
U Vermont	1	3		1
Yale U		6	2	1
MIDDLE ATLANTIC	(36)	(41)	(41)	(43)
A Einstein			2	2
Albany	2	3	4	2
Columbia U	2		3	3
Cornell U	2		3	1
Georgetown U	2	5	2	1
George Washington U	2	2	1	1
Hahnemann	3	2	3	5
Jefferson	3		1	2
Johns Hopkins U	1		2	
U Maryland			1	1
Med Coll Penn	1		3	2
Mt Sinai	1	2	1	1
New Jersey	1	3		
New York Medical	5	7	5	4
New York U		3	4	3
Philadelphia Osteo				1
U Penn	2	1		1
Penn State		1		
U Pittsburgh	2	1		1
U Rochester	3	3	2	2
Rutgers U		2	2	
State U (NY)	4	4	2	8
Temple U		2		2
SOUTH	(6)	(1)	(14)	(9)
Baylor U			1	
Duke U			1	1
East Virginia				1
Emory U	1			1
U Florida	1		1	
MC Virginia			3	
U Miami	1		2	2
Mississippi				1
U Tenn			2	
U Texas	1		1	
Tulane U	1			1
U Virginia	1	1	1	2
U West Virginia			2	
MID-WEST	(11)	(14)	(9)	(12)
U Arizona			1	
Case West Res				1
U Cincinnati	1	1		1
Chicago (Osteo)	1			
Colorado U			1	
Creighton U	2			2
U Indiana		2		
U Iowa				1
U Kansas			1	1
Loyola U		1		
U Michigan	1			1
Michigan State	1	1	1	
U Minnesota		1		2
U Nebraska		1		1
Northwestern U	1		1	
St Louis U	1	1	4	1
S Illinois U		2		
Wayne State	1	2		
U Wisconsin	2	2		1
WEST	(7)	(2)	(3)	(2)
U California	2			1
U Colorado	1			1
U New Mexico	1			
U Oregon			1	
U Washington	3	2	2	
CANADIAN SCHOOLS	(0)	(0)	(0)	(1)
Montreal U				1
FOREIGN SCHOOLS	(8)	(3)	(3)	(5)
Beirut		1		
Bologna	1			
Brussels	3			
Catholic (Seoul)			1	
El-Azhar		1		
Guadalajara	2	1	1	2
Juarez				1
Lisbon				2
RCS, Ireland			1	
Roma	2			

ing Program allows both the institutions and the applicants to rank, in confidence, their separate choices in a manner such that the final outcome will reflect appointment decisions which are mutually acceptable to the prospective intern as well as the considered hospital. Obviously, certain hospital positions will be wanted by many, while others will experience great difficulty in recruiting candidate interns. The educational quality of the interns recruited by our hospitals provide us therefore with some measure of how our local institutions are viewed by the graduates of the other medical schools of the United States as desirable training institutions.

While all of the eight hospitals affiliated with Brown University play an active role in some form of residency training, first-year graduate medical education training programs (sometimes called internships) are maintained in only five of these institutions (Rhode Island, Women and Infants, Miriam, Roger Williams General, Memorial Hospitals). The following list represents the approved patient-care training programs in these hospitals: Family Medicine (Director: Louis Hochheiser, MD), Internal Medicine (Directors: Paul Calabresi, MD, Milton Hamolsky, MD, Herbert Lichtman, MD), Pediatrics (Director: Leo Stern, MD), Obstetrics and Gynecology (Director: David Nichols, MD) and Surgery (Director: Donald Gann, MD).

Thirty-three of the 103 new interns are women, representing 32 per cent of those recruited. In 1979-80, 21 per cent of the new interns were women.

The data concerning medical schools attended by the State of Rhode Island interns are summarized in Tables 1 and 2, representing information regarding the last four groups. Clearly the new group of medical house officers are not clustered around a few schools, but rather represent the educational diversity of 49 US medical schools, 1 US school of osteopathy, 1 Canadian medical school and 3 foreign medical schools. (Last year there were 46 different US campuses listed and 3 foreign medical schools). Interestingly, all nine of the New England medical schools are represented in the new cadre of interns. The medical school origins of our house staff continues to be broadly based, a sign of the health of the graduate medical education programs in the greater Providence region.

The places of residence of the new interns are summarized in Table 3 (and compared with the three preceding groups). The northeastern region and particularly the states of New York, Rhode Island, Massachusetts, Pennsylvania and Connecticut continue to be the more commonly listed states

Table 2. Regional Pattern of Medical Schools Attended by State of Rhode Island Interns (1977-78, 1978-79, 1979-80, and 1980-81)

Region:	1977-78	1978-79	1979-80	1980-81
NEW ENGLAND	23 (25%)	34 (36%)	27 (28%)	31 (30%)
MIDDLE ATLANTIC	36 (40%)	41 (43%)	41 (42%)	43 (42%)
SOUTH	6 (7%)	1 (1%)	14 (14%)	9 (9%)
MIDWEST	11 (12%)	14 (15%)	9 (9%)	12 (12%)
WEST	7 (8%)	2 (2%)	3 (3%)	2 (2%)
CANADIAN	0	0	0	1 (1%)
FOREIGN	8 (9%)	3 (3%)	3 (3%)	5 (5%)

Table 3. Places of Residence, 1977-78, 1978-79, 1979-80, and 1980-81 State of Rhode Island Interns

Region:	1977-78	1978-79	1979-80	1980-81
NEW ENGLAND	(28)	(41)	(36)	(41)
Connecticut	5	7	6	6
Maine			2	
Massachusetts	7	19	15	11
New Hampshire			1	2
Rhode Island	15	14	12	22
Vermont	1	1		
MIDDLE ATLANTIC	(40)	(36)	(35)	(42)
District of Columbia		1	1	
Maryland		1	3	2
New Jersey	8	6	5	4
New York	24	23	20	25
Pennsylvania	8	5	6	11
SOUTH	(5)	(4)	(16)	(9)
MIDWEST	(14)	(10)	(6)	(8)
WEST	(3)	(3)	(4)	(2)
CANADIAN				(1)
FOREIGN	(1)	(1)	(0)	(0)
Totals	91	95	97	102

although there is a significant representation from the south, midwest and far-west. The one foreign intern in this year's contingent is a citizen of Canada.

It had been stated previously in this column that the patient care internships in those hospitals affiliated with Brown University were occupied by well-qualified graduates of American medical schools. Certainly the 1980-81 cohort of interns reaffirms the belief that the Brown University consortium of teaching hospitals is widely viewed as desirable for internship and residency. Few physicians would doubt that the presence of a well-trained house staff has been a major factor in permitting the State of Rhode Island to become medically self-sufficient.

Stanley M. Aronson, MD
Dean of Medicine
Brown University

EDITORIALS

Insomnia: The Need to Be Awake

Many patients, not just non-psychotic psychiatric patients, complain of difficulty in falling asleep and apply much pressure for suitable medication. Sometimes it seems to be a symptom of which they complain the most: "I want to go to sleep." "I just want a good night's sleep." "Without sleep I'll go crazy." We may want to take the quick and easy solution for them as for ourselves by prescribing a medication. I have found that having the patient explore the need to be awake helps the patient focus on the process of what is going on rather than trying to achieve the immediate goal, sleep. I will often ask the patient what he/she was trying *not* to think of after going to bed. This involves the patient actively and gives him/her something to do at a critical time and a new focus of attention.

Insomnia means being awake as if one is on guard duty and in control of what one is paying attention to. What does the person not want to be aware of? — undigested residuals of the day's experiences, reminders of present or past unpleasant emotional experiences, anticipation of emotional situations to occur the following day, the avoidance of the free associations that are part of the process of relaxing, letting go. To be in power and control the patient must direct his/her associations to that which he/she approves and accepts. This requires alertness and vigilance and avoidance of what is subconscious or unconscious. Despite the seeming paradox, giving up control (letting associations occur) lets the patient know what the problem is and puts the patient in the power-control position of deciding how important it really is. Is there an emergency? If so, what can or has to be done about it now or can it wait until morning? This process may reveal and give openings to unsuspected fears, anxieties, hostilities and loves that would otherwise go undetected by the physician and yet play a part in the patient-physician relationship and a patient's medical compliance.

(Definitions: A "want" is more conscious in origin. A "need" is more unconscious in origin.)

Joseph M. Zucker, MD

Who Is Responsible for Trauma Care?

The recent effort to establish the Rhode Island Hospital as a state Trauma Center follows a nationwide trend and is based on the premise that "the sophisticated definitive care" needed to reduce trauma morbidity and mortality is available only in specially designated facilities. To date, however, there has been little communication on this designation with the physicians and others in the community already deeply involved in the care of trauma victims. The dialogue has been almost exclusively between the Department of Health and the Rhode Island Hospital, an approach which cannot secure community cooperation so vital to the successful operation of any centralized facility.

Is a central facility the best approach to upgrading of trauma care in Rhode Island? Do Rhode Island excess mortality rates justify the costs of a centralized facility? It is estimated that the annual cost of staffing alone for the facility will be $3.6 million. Will the state be willing and able to support a Trauma Center in a manner which will allow continued excellence?

The papers on trauma elsewhere in this issue were presented to an overflow audience of physicians, nurses, and Emergency Medical Technicians (EMTs). There is considerable expertise in trauma management presently available in the Rhode Island community. How will this resource be used in the development of a Trauma Center?

Arnold H. Herman, MD, FACS

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RADIOGRAPHIC CASE OF THE MONTH

History:

20 year old male with intermittent episodes of abdominal and extremity pain.

Radiographic Findings:

The radiograph of the left hip and a lateral view of the thoracic spine are presented. The left hip demonstrates flattening of the femoral head with a lucency immediately underlying it. The acetabulum is not affected. Generalized coarsening of bony trabecula is seen. There is bony density in the sub-capital portion of the femoral head. A second bony density is seen within the normal outlines of the cortex forming a "bone within a bone" appearance. The thoracic spine shows "cupping" of the thoracic vertebra. In addition to the cupped appearances is a squared off "stepladder" appearance in the plates of the vertebral bodies.

For diagnosis and discussion turn to next page.

Differential Diagnosis:

The flattened femoral head with subcortical resorption and a normal acetabulum is classical for aseptic necrosis of bone. Aseptic necrosis has a wide differential diagnosis. The most common entities include interruption of the blood supply such as in sickle cell anemia, caisson disease, and trauma. Other systemic causes include pancreatitis, rheumatoid arthritis, and Gaucher's disease. Some drugs such as meperidine and steroids can produce these findings. The coarsened trabeculae as described above may be seen in any severe anemia. The "bone within a bone" appearance is seen with sickle cell anemia, osteopetrosis, Paget's disease, hypervitaminosis D and increased phosphorus ingestion. The "cupped" appearance of the vertebra can be seen in osteoporosis or sickle cell anemia but the squared off appearance of the cupped end plates is seen in sickle cell anemia.

Diagnosis:

Sickle cell anemia

Discussion:

Sickle cell anemia is a congenital hereditary disease which occurs almost exclusively in black people but is also seen rarely in people of Mediterranean origin. The disease is transmitted as a Mendelian dominate. The red blood cells are abnormal in that when deprived of oxygen they assume a sickled shape and thereby produce occlusions of small capillaries. This may produce local anoxia and infarction. Any tissue system may be affected but the skeleton, gastrointestinal tract, lungs, kidneys or brain are the most common sites.

Radiologic changes in the skeleton are the result of anemia and localized infarcts. There is an overall osteoporotic pattern with coarsening of trabecula.

Characteristic findings include:

1. *Skull* — The diploic space is customarily widened and in severe cases there is a vertical striation due to increased marrow production of blood. This is the "hair on end" appearance. The paranasal sinuses are not affected which helps to separate this from Cooley's anemia.

2. *Spine* — There is a bi-concave defect in the vertebral bodies known as "cupping." This is felt to be due to softening of bone and herniation of the nucleus pulposis into the vertebral body. However, in some cases this cupping has a squared off appearance which is felt to be due to infarction in the center of the vertebral body. This finding is characteristic of sickle cell anemia.

3. *Hands and feet* — Soft tissue swelling and periosteal reaction may be seen. Destructive changes in the shaft or ends of the phalanx may be seen. Periosteal new bone and cortical thickening may mimic Caffey's disease. It is thought that there may be an association with Salmonella osteomyelitis in the digits.

4. *Long bones* — Interruption of blood supply to the femoral or humeral heads may produce aseptic necrosis. Coarsened trabecular pattern is common. Dense solid areas may be due to medullary infarction. Endosteal resorption and subsequent repair may produce the layering of new bone described above as "bone within a bone."

Kidneys may be small due to multiple infarctions. Papillary necrosis is common. Splenomegaly is common early in the disease although in later stages the spleen becomes shrunken due to multiple infarctions. Congestive heart failure is common. Intestinal infarction is also common due to interruption of gastrointestinal blood supply.

Thalassemia does not produce the cupping of vertebral bodies, aseptic necrosis, or "bone within a bone" appearance. In addition, in thalassemia the paranasal sinuses may be obliterated due to marrow hypertrophy. Iron deficiency anemia seldom has severe bone changes as described above for sickle cell anemia.

Allan M. Deutsch, MD
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Sanford Schatz, MD

References

[1]Murray RO, Jacobson HG: The Radiology of Skeletal Disorders. Baltimore, Williams & Wilkens, 1978, pp 590-591.
[2]Moseley JE: Bone Changes in Hematologic Disorders. New York, Grune & Stratton, 1963, pp 1-44.

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. . . *Harvard Medical School Alumni Bulletin,* February, 1980.

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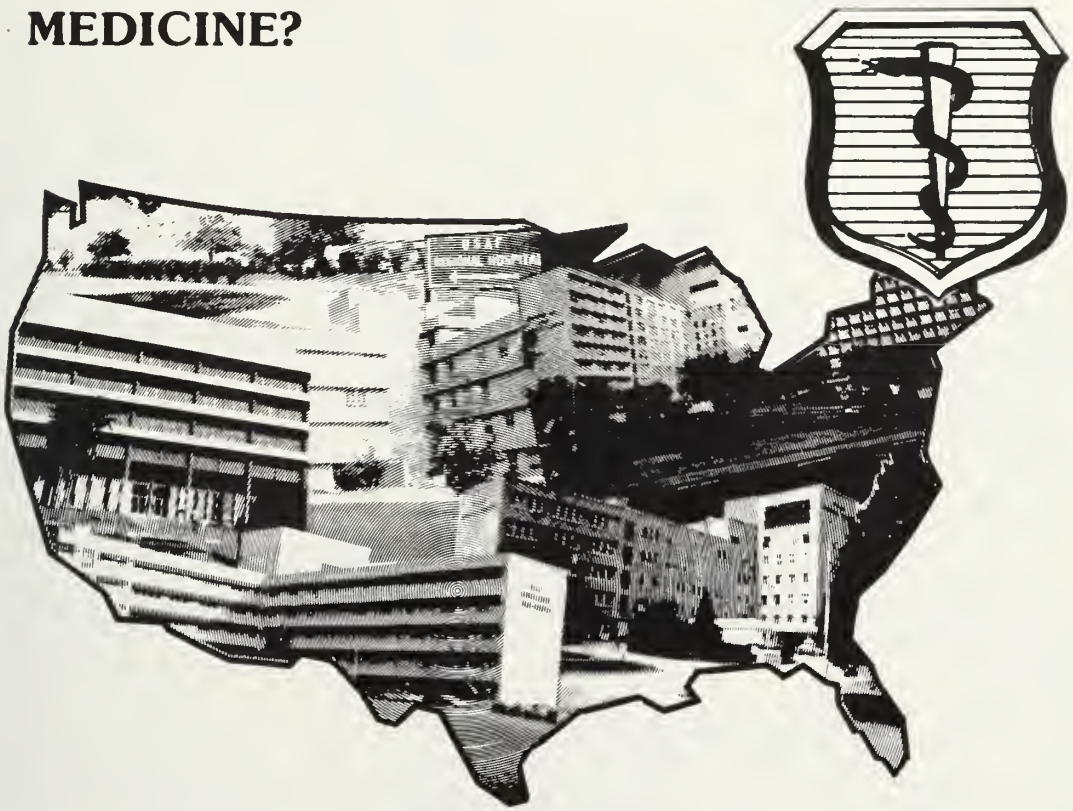

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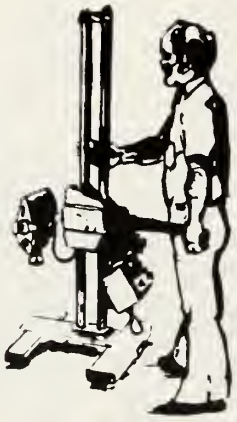

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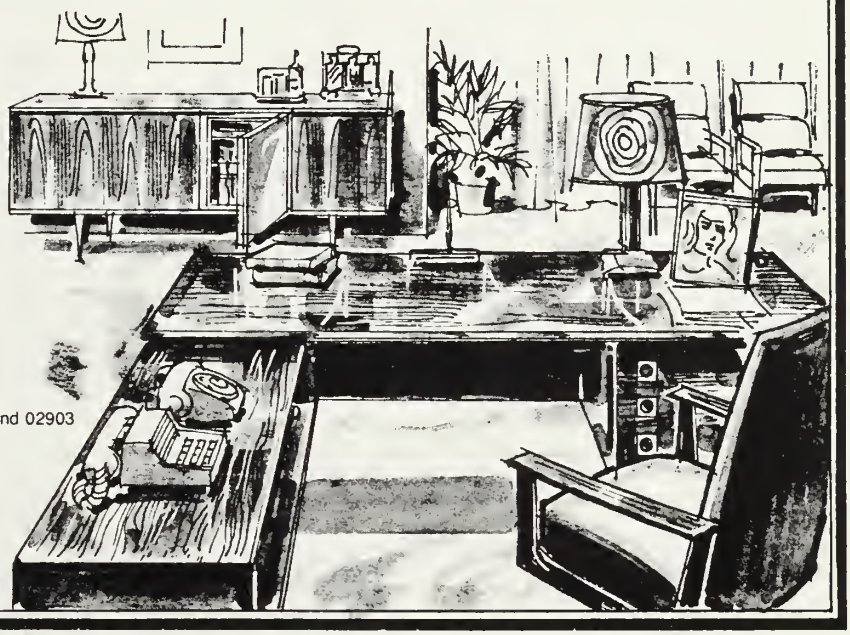

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CONTRAINDICATIONS Advanced arteriosclerosis, hyperthyroidism, known hypersensitivity, or idiosyncrasy to the sympathomimetic amines, glaucoma Agitated states Patients with a history of drug abuse During or within 14 days following the administration of monoamine oxidase inhibitors, (hypertensive crises may result)

WARNINGS If tolerance develops, the recommended dose should not be exceeded in an attempt to increase the effect, rather, the drug should be discontinued Tenuate may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle, the patient should therefore be cautioned accordingly *Drug Dependence* Tenuate has some chemical and pharmacologic similarities to the amphetamines and other related stimulant drugs that have been extensively abused There have been reports of subjects becoming psychologically dependent on diethylpropion The possibility of abuse should be kept in mind when evaluating the desirability of including a drug as part of a weight reduction program Abuse of amphetamines and related drugs may be associated with varying degrees of psychologic dependence and social dysfunction which, in the case of certain drugs, may be severe There are reports of patients who have increased the dosage to many times that recommended. Abrupt cessation following prolonged high dosage administration results in extreme fatigue and mental depression, changes are also noted on the sleep EEG. Manifestations of chronic intoxication with anorectic drugs include severe dermatoses, marked insomnia, irritability, hyperactivity, and personality changes The most severe manifestation of chronic intoxications is psychosis, often clinically indistinguishable from schizophrenia *Use in Pregnancy* Although rat and human reproductive studies have not indicated adverse effects, the use of Tenuate by women who are pregnant or may become pregnant requires that the potential benefits be weighed against the potential risks *Use in Children* Tenuate is not recommended for use in children under 12 years of age

PRECAUTIONS: Caution is to be exercised in prescribing Tenuate for patients with hypertension or with symptomatic cardiovascular disease, including arrhythmias Tenuate should not be administered to patients with severe hypertension Insulin requirements in diabetes mellitus may be altered in association with the use of Tenuate and the concomitant dietary regimen Tenuate may decrease the hypotensive effect of guanethidine The least amount feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdosage Reports suggest that Tenuate may increase convulsions in some epileptics Therefore, epileptics receiving Tenuate should be carefully monitored Titration of dose or discontinuance of Tenuate may be necessary

ADVERSE REACTIONS: *Cardiovascular* Palpitation, tachycardia, elevation of blood pressure, precordial pain, arrhythmia One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride *Central Nervous System* Overstimulation, nervousness, restlessness, dizziness, jitteriness, insomnia, anxiety, euphoria, depression, dysphoria, tremor, dyskinesia, mydriasis, drowsiness, malaise, headache, rarely psychotic episodes at recommended doses In a few epileptics an increase in convulsive episodes has been reported *Gastrointestinal* Dryness of the mouth, unpleasant taste, nausea, vomiting, abdominal discomfort, diarrhea, constipation, other gastrointestinal disturbances. *Allergic* Urticaria, rash, ecchymosis, erythema, *Endocrine* impotence, changes in libido, gynecomastia, menstrual upset *Hematopoietic System* Bone marrow depression, agranulocytosis, leukopenia *Miscellaneous* A variety of miscellaneous adverse reactions has been reported by physicians. These include complaints such as dyspnea, hair loss, muscle pain, dysuria, increased sweating, and polyuria

DOSAGE AND ADMINISTRATION: Tenuate (diethylpropion hydrochloride) One 25 mg tablet three times daily, one hour before meals, and in midevening if desired to overcome night hunger. Tenuate Dospan (diethylpropion hydrochloride) controlled-release One 75 mg tablet daily swallowed whole, in midmorning Tenuate is not recommended for use in children under 12 years of age.

OVERDOSAGE: Manifestations of acute overdosage include restlessness, tremor, hyperreflexia, rapid respiration, confusion, assaultiveness, hallucinations, panic states Fatigue and depression usually follow the central stimulation Cardiovascular effects include arrhythmias, hypertension or hypotension and circulatory collapse Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps Overdose of pharmacologically similar compounds has resulted in fatal poisoning, usually terminating in convulsions and coma Management of acute Tenuate intoxication is largely symptomatic and includes lavage and sedation with a barbiturate Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendation in this regard Intravenous phentolamine (Regitine®) has been suggested on pharmacologic grounds for possible acute, severe hypertension, if this complicates Tenuate overdosage

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References: 1. Citations available on request from Medical Research Department, MERRELL-NATIONAL LABORATORIES, Cincinnati, Ohio 45215 2. Hoekenga, M T., O'Dillon [Dillon], R H., and Leyland, H M. A comprehensive review of diethylpropion hydrochloride In, Central Mechanisms of Anorectic Drugs, S Garattini and R Samanin, Ed., New York, Raven Press, 1978, pp 391-404

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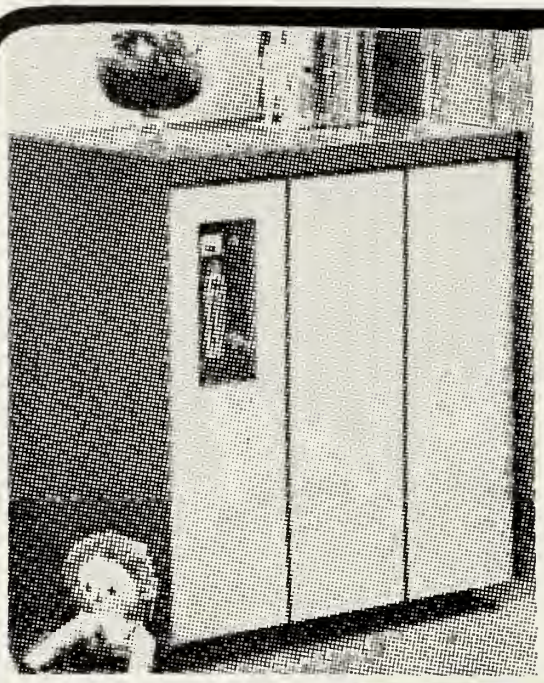

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In one year in the United States trauma is responsible for 65 million injuries, over 100,000 deaths, $62 billion in health care costs, one-third of all hospital admissions, 22 million patient days, and more deaths than all other causes combined between the ages of 15 and 24. The pages which follow present immediate approaches and solutions for trauma victims with multiple injuries, including intra-abdominal injuries, chest injuries, peripheral arterial damage, facial injuries, acute respiratory failure, and other acute problems demanding immediate intensive attention. The papers are from The Second Annual Miriam Hospital Surgical Symposium. Titled "Immediate Care of the Traumatized Patient", it was held at The Miriam Hospital, Providence, Rhode Island on May 5, 1979.

I. Immediate Evaluation of the Multiply Injured Patient

Arnold H. Herman, MD, FACS

Trauma has been a major problem facing physicians since the priests of Asklepios cleansed and bandaged sword wounds over 1,000 years ago. In our modern society in the United States 100,000 die and 500,000 are disabled each year from trauma. It is the leading cause of death between ages 1 to 44, and between the ages of 15 and 24 accidents cause more death than all other causes together. Trauma accounts for 22 million hospital days a year at a cost of $47.1 billion. Half this amount is due to auto accidents alone.

Initial evaluation of the multiply injured patient must be done rapidly and accurately. Under emergency conditions, a systematic approach exerts a stabilizing influence against the pressures and constraints of emotion, confusion, and haste.

Knowledge of the exact nature of the injury is not needed initially since certain clinical findings will dictate which emergency measures must be taken. Important observations are pulse, respiration,

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blood pressure, body temperature, skin color, pupils, state of consciousness, ability to move, and reaction to pain. The immediate evaluation must involve triage into categories of priorities of treatment: in order of importance is life, limb, function, and cosmesis.

Of highest priority are those injuries which interfere with vital physiologic functions and are an immediate threat to life, such as respiratory, cardiovascular, hemorrhage, neck, shock, and internal bleeding problems. Of second priority are those injuries which are severe, but offer no immediate threat to life. Vital signs are stable. These include cranio-cerebral and spinal cord injuries as well as burns.

Of the third priority are those injuries which produce occult damage such as lower genito-urinary injuries, peripheral nerve or vascular injuries, soft tissue injuries after hemorrhage is controlled, and fractures after splinting.

This is done by simultaneously evaluating the patient with all your senses. As you feel the pulse, observe for bleeding and for the pattern of respiration. At the same time, talk to the patient to determine his state of consciousness. More is missed by not looking than by not knowing.

There are seven axioms in the immediate care of the multiply injured patient: 1. The airway should be maintained; 2. hemorrhage should be controlled; 3. open or sucking chest wounds should be sealed; 4. adequate treatment for shock should be instituted; 5. fractures should be splinted; 6. rapid evaluation of the patient for further injuries should be carried out with appropriate treatment instituted; and 7. the patient should be continually evaluated regardless of other obligations.

The most critical requirement for the injured patient is the securing of an airway. This may be accomplished by removing a foreign body, positioning the head, or inserting an oral airway. An esophageal airway allows adequate ventilation without direct intubation of the trachea. Cricothyroidotomy, insertion of a tracheal catheter, nasotracheal or orotracheal intubation, or tracheostomy may be necessary for securing the airway.

The second most critical need for the injured patient is control of bleeding and support of the circulation. Direct local pressure over any bleeding point can control the bleeding. Pressure applied to a major vessel proximal to the injury allows control of bleeding, as does a tourniquet applied proximal to the injury. A splint will assist in the control of bleeding at fracture sites even if the fracture is not reduced. The wound should always be covered even if not bleeding.

Using large-bore intravenous cannulae, saline or Ringer's lactate solutions should be infused via the upper extremities or the subclavian or internal jugular routes. A central venous pressure (CVP) catheter and Foley bladder catheter are also needed early in the treatment of the multiply injured patient.

At this point the ability of the patient to move and feel should be determined. If the patient is unconscious and one cannot establish whether or not there has been a spinal cord or vertebral injury, the patient must be treated as a neck or spinal cord injury case until proven otherwise.

Observe the limbs for deformity, and splint fractures at this time. Do not reinsert protruding intestines. Do not remove foreign objects. Remember that head injury patients who are hypotensive have another injury to account for their low blood pressure.

With respiration and bleeding under control, a thorough physical examination must be carried out.

Neck injury should be suspected in the unconscious patient when there is flaccid areflexia, especially with a flaccid rectal sphincter; when there is diaphragmatic breathing; when the patient can flex but not extend the forearm; or when pain response is present above but not below the clavicles; or when there is priapism.

Observe for venous distention or subcutaneous emphysema. Check for otorrhea or rhinorrhea. Palpate the rib cage for tenderness or subcutaneous emphysema, and observe for asymmetry, bulging, or paradoxical motion. Palpate the pelvis for fracture by compression of the iliac crests and pubis.

Observe the meatus before introducing the urethral catheter. If blood is present, a urethrogram is probably indicated before attempting to pass the catheter. Examine the abdomen and flanks for distention, discoloration, tenderness, muscle spasm, masses, organomegaly, pulsation, thrills, and bruits. Rectal examination may reveal a "floating" prostate which indicates urethral disruption.

Peripheral pulses should be checked for their presence and equal quality bilaterally. If there is a decreased pulse it may be on the basis of adjacent fracture, ruptured vessel, compression within a muscle compartment, or constriction from a circumferential burn.

If there is no deformity, the upper and lower extremities should be moved through a full range of

motion at all joints. Do not forget that the patient has a back and a perineum! Both must be evaluated, regardless of other injuries.

While all of this activity is continuing, someone should be attempting to elicit information about the patient's past medical history and the details of the accident from family and observers. It is important to know the position of the patient at the time of the accident and whether or not he was trapped within or beneath the vehicle. A description of the blood at the scene is helpful in assessing the total blood loss, since 100 ml covers one square foot on the floor. Also remember that there are 500 ml near an arm fracture and 2000 ml in any pelvic fracture.

Observers and ambulance attendants can tell whether or not the patient has had a change in consciousness or perhaps a "lucid interval".

If a gunshot wound is involved, the type of firearm is critical, since the 400 foot per second .22 caliber bullet causes far less damage than the 1500 foot per second .357 magnum.

If the patient has fallen from a height or has had rapid deceleration in an auto accident, possible injury to the major vessels or retroperitoneum must be considered. Any lower leg fracture or os calcis fracture may be associated with a dislocated hip or compression fracture of the first or second lumbar vertebra.

A planned approach to the multiply injured patient will result in a more rapid evaluation and more successful treatment. Only in this way can we hope to reduce the heavy toll trauma takes of our population.

References

[1]The Committee on Injuries, American Academy of Orthopaedic Surgeons. Emergency Care and Transportation of the Sick and Injured. ed 2. Chicago, American Academy of Orthopaedic Surgeons, 1977.

American College of Surgeons. Early Care of the Injured Patient. ed 2. Philadelphia, WB Saunders, 1976.

[3]Dudley HA (ed): Hamilton Bailey's Emergency Surgery. ed 10. Bristol, England, J Wright and Sons, 1977.

[4]Schwartz GR. Principles and Practice of Emergency Medicine. Philadelphia, WB Saunders, 1978.

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II. Advanced Cardiac Life Support

William E. Kaye, MD

Advanced Cardiac Life Support includes: (1) artificial ventilation and cardiac compression (basic cardiac life support); (2) adjuncts for breathing, ventilation, and circulation; (3) monitoring and dysrhythmia recognition; (4) defibrillation and synchronized cardioversion; (5) intravenous and other invasive techniques; (6) drugs for emergency cardiac care; (7) acid base balance; and (8) stabilization and transportation. The *primary emphasis* of advanced cardiac life support must be the *prevention of cardiopulmonary arrest* and the *preservation of normal brain function*. If cardiopulmonary arrest does occur, then the patient should ideally be resuscitated and stabilized at the scene of the arrest. Only after the patient is stabilized should he be transported, with continuous monitoring and support of cardiovascular and pulmonary function, to another site for definitive care.

The initial assessment of any patient must include the level of brain function, patency of airway, adequacy of breathing, adequacy of cardiac function, and the presence or absence of significant bleeding. Brain function can be evaluated by determining the patient's level of consciousness. While gently shaking the patient, the rescuer should ask "Are you OK?" If the patient is lying face down, it may be necessary to turn the patient onto his back. However, in the injured patient one must exercise extreme caution to avoid compounding the injuries with manipulation. The airway should be opened either by tilting the head back and lifting the chin

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forward, or, if cervical trauma is suspected, the head should be stabilized and the modified jaw thrust utilized to open the airway. The rescuer assesses adequacy of breathing by placing his ear next to the patient's mouth while looking toward the chest. In this manner he can simultaneously look to see if the chest rises and falls and listen and feel for air movement from the patient's mouth against his ear. If breathing is present, the airway should be maintained and the primary assessment continued. If breathing is absent, mouth-to-mouth breathing should be initiated with four quick, full breaths. The rescuer should next proceed to evaluate cardiac function by palpating the carotid pulse. If the pulse is present, he should maintain the patient's airway and continue mouth-to-mouth breathing if indicated. If the pulse is absent, external cardiac compression should be begun immediately. Finally, the rescuer should examine the patient for evidence of major bleeding and control any such bleeding.

The above primary assessment constitutes *Basic Cardiac Life Support*. Under no circumstances should one defer or interrupt Basic Cardiac Life Support in order to seek an adjunct that is not immediately available. Mouth-to-mouth breathing and closed chest cardiac compression are adequate to sustain life until adjunctive equipment and skills of Advanced Cardiac Life Support are available.

Ventilation

Intubation of the airway, either with an esophageal obturator airway or an endotracheal tube, should be performed as soon as practical following initiation of basic cardiac life support. This isolates the airway, preventing aspiration of gastric contents, and permits the delivery of high concentrations of oxygen.

Although mouth-to-mouth (or mask) ventilation is adequate to sustain life during cardiopulmonary resuscitation, moderate hypoxemia occurs. The expired air of the rescuer contains approximately 17 per cent oxygen. Therefore, even with normal cardiac output and pulmonary function, the maximum partial pressure of oxygen in the alveoli cannot exceed 80 mmHg.

Cardiac output during external cardiac compression is, at best, 30 per cent of normal. This produces a low mixed venous oxygen content so that, even in the absence of increased intrapulmonary shunting, there will be significant arterial oxygen desaturation. During basic cardiac life support there is increased physiological right-to-left shunting in the lung. Not only is there a volume of pulmonary capillary blood in contact with totally unventilated alveoli, but significant ventilation/perfusion inequality exists as well. Desaturated mixed venous blood passing across the physiological shunts contaminates arterialized blood and leads to severe arterial oxygen desaturation. Increasing inspired oxygen concentration will both elevate alveolar oxygen tension and decrease the arterial desaturation produced by the venous admixture from the mismatch of pulmonary ventilation and perfusion.

Equipment

Before the airway is intubated, however, the mouth-to-mask unit (pocket mask) may be used. This is a simple and effective adjunct that requires minimal training. The mouth-to-mask unit overcomes the aesthetic problems that often lead to delay in mouth-to-mouth ventilation and can provide 40 - 50 per cent inspired oxygen concentration if the side port is connected to an oxygen flow of 10 liters/minute. This unit is also more effective than the ubiquitous bag-valve-mask unit. Except for those who utilize the bag-valve-mask unit frequently, or when two rescuers are available (one to hold the mask and the other to ventilate), most personnel may have great difficulty in ventilating adequately a non-intubated patient with a bag-valve-mask unit. On the other hand, large tidal volumes can be easily delivered with a mouth-to-mask device.

The esophageal obturator airway requires a minimum of training, allows one to deliver a high oxygen concentration, and prevents aspiration of gastric contents. However, the esophageal obturator airway must not be used in children, in conscious patients, or in patient with known esophageal disease or injury. When an experienced individual is available, either at the initial intubation or before removing the esophageal obturator airway, or both, a cuffed endotracheal tube should be placed. This device provides optimal control of the airway.

Although a bag-valve-mask device may be difficult to utilize in a nonintubated patient, for the intubated patient the bag-valve-mask unit, with supplemental oxygen in a reservoir bag, can deliver a high inspired oxygen concentration. A manually triggered oxygen powered breathing device (demand valve) can deliver 100 per cent oxygen and is commonly used in pre-hospital resuscitation. Because it delivers oxygen under high pressure, gastric insufflation with resultant regurgitation of gastric contents can be a problem in a non-intubated patient. The high pressures may produce pulmonary injury in infants and children; therefore, the device should be used only on adults.

Perfusion

As long as there is no adequate spontaneous heartbeat, external cardiac compression must be continued throughout any resuscitation attempt. Except during transport or during intubation, chest compression should not be interrupted for more than five seconds. During transport or intubation, interruptions for up to 15 seconds may be necessary. But any prolonged interruption should be preceded by a period of ventilation and cardiac compression, and such interruptions should be kept at a minimum. Mechanical adjuncts for artificial circulation can be effective if they are used by a trained individual and if their performance is continuously monitored.

Monitoring Cardiac Rhythm

In the pre-arrest phase, both in the patient with suspected myocardial ischemia or infarction and the trauma patient, cardiac dysrhythmias commonly occur. Evidence of ventricular ectopic activity is often the harbinger of more dangerous (or lethal) dysrhythmias. Prompt institution of electrocardiographic monitoring of cardiac rate and rhythm, both in the field and in the hospital, will allow these dysrhythmias to be detected and appropriately treated. If premature ventricular complexes are frequent, multiform, and early, or occur in pairs or runs, they should be suppressed with lidocaine, as described later. Evidence of impaired conduction or bradydysrhythmias may require the insertion of a transvenous pacemaker. Sinus bradycardia, if accompanied by significant hypotension (that does not respond to elevating the patient's legs) or ventricular escape beats, should be treated initially with intravenous atropine, 0.5 mg, repeated at five minute intervals to a maximal dose of 2 mg until either the heart rate is above 60 or the systolic pressure reaches 90, and the ventricular escape beats are suppressed. Excessive atropine may *produce* ventricular tachycardia or fibrillation. Therefore, it should be used cautiously and only for the above indications.

Pulseless Patient

In the pulseless patient, there are three possible cardiac rhythms: ventricular fibrillation, ventricular asystole (standstill), or electromechanical dissociation.

Ventricular fibrillation, characterized by undulating, irregular waves on the electrocardiogram, is chaotic electrical depolarization of the heart muscle with individual fibers contracting randomly. There is no effective contraction of the heart as a whole and, therefore, no forward flow.

Asystole is commonly seen as an agonal rhythm. It is recognized by an irregular line with intermittent bizarre idioventricular complexes on the electrocardiogram. If one sees an absolutely straight line on the electrocardiogram, one should suspect disconnection of a lead from the patient, rather than asystole.

Electromechanical dissociation is characterized by the presence of an electrical rhythm on the electrocardiogram, with absent pulse. Therefore, whenever one sees a rhythm for the first time or a change of rhythm on the electrocardiogram, the pulse must be checked to exclude electromechanical dissociation. This dysrhythmia is commonly seen as an agonal rhythm and may also accompany cardiac rupture. As with asystole, it is often very difficult to reverse.

Defibrillation

If the patient is under observation and being monitored with an electrocardiogram, and ventricular fibrillation is promptly recognized, it is essential to defibrillate the patient promptly before instituting mouth-to-mouth breathing or chest compression and before administering any drugs. If the initial defibrillation attempt is unsuccessful, then cardiopulmonary resuscitation (CPR) should be immediately implemented.

However, if a patient is discovered after the cardiac arrest has occurred, or if CPR has been in progress for a few minutes and ventricular fibrillation is subsequently diagnosed, it is imperative to provide ventilation and circulation, and administer appropriate drugs before attempting to defibrillate. Otherwise defibrillation may be unsuccessful, or the electrical shock may convert ventricular fibrillation in an anoxic heart to asystole, which may be far more difficult to reverse.

For defibrillation of adults one should utilize maximum energy levels (320-400 watt seconds). If at any time sinus rhythm or an apparently viable rhythm is recognized on the electrocardiogram, the pulse must be checked to guarantee effective cardiac contraction. Whenever the defibrillation attempt is unsuccessful, ventilation, cardiac compression, and further drug therapy should be continued before another attempt is made. It is irrational to "defibrillate" asystole or electromechanical dissociation!

Intravenous Lifeline

As soon as possible, an intravenous infusion lifeline should be placed. Cannulating a peripheral vein is

both rapid and simple. If effective cardiac compression is being performed, any drug injected into a peripheral vein will be distributed throughout the circulation. Veins on the wrist or in the antecubital fossa, the long saphenous at the ankle, or the external jugular vein in the neck are all commonly used. However, in circulatory collapse, cannulation of a peripheral vein may be impossible. The femoral vein is a large central vein that is easily cannulated during circulatory collapse. Placing a lifeline into the femoral vein does not require interruption of ventilation or chest compression during cardiac arrest, because of the distance from the neck to chest. The internal jugular and subclavian approaches demand that ventilation and chest compression be interrupted. Unless one is highly skilled in inserting such a line within 15 seconds, it is best deferred until the patient is more stable.

If the patient is already intubated with an endotracheal tube, some of the emergency drugs can be administered through this tube. Epinephrine, atropine and lidocaine have been shown to be effective by this route. The same dose that is administered intravenously is instilled directly into the endotracheal tube. When the patient is ventilated, the drug is distributed and absorbed.

Intracardiac injections should be avoided. Intracardiac injections necessitate interruption of cardiac compression. Many complications, including intramyocardial injection, coronary artery laceration, pericardial tamponade, and pneumothorax, have been reported.

Drug Therapy

Epinephrine and sodium bicarbonate are the primary essential drugs. They should be administered to any pulseless patient whether the underlying dysrhythmia is ventricular fibrillation, asystole, or electromechanical dissociation.

Epinephrine elevates peripheral resistance and perfusion pressure, thereby increasing coronary blood flow. It improves myocardial contractility, and may stimulate spontaneous contractions in the presence of asystole or electromechanical dissociation. It changes fine ventricular fibrillation to coarse fibrillation, which is more susceptible to termination by countershock. The dose is 0.5 mg (usually 5 ml of a 1:10,000 dilution) intravenously or via an endotracheal tube initially. It can be repeated at 5 minute intervals if cardiac arrest persists.

Sodium bicarbonate administration is necessary because of the metabolic acidosis that occurs during sustained cardiac arrest. An initial dose of 1 mEq/kilogram intravenously is recommended. Subsequent doses should be guided by frequent blood gas determinations. However, if cardiac arrest persists, and one does not have access to blood gas determinations, half the initial dose should be repeated intravenously every 10 minutes. There are several problems with bicarbonate that must be emphasized. In the process of neutralizing excess hydrogen ions with bicarbonate, carbon dioxide is generated. Therefore, the patient must be adequately ventilated before bicarbonate is given. Excessive bicarbonate produces metabolic alkalosis, which leads to refractory dysrhythmias. Metabolic alkalosis also shifts the oxyhemoglobin dissociation curve to the left, increasing the affinity of hemoglobin for oxygen, which interferes with peripheral oxygen delivery. Potentially lethal hypernatremia and hyperosmolality are also commonly produced. If a patient who sustains a cardiac arrest is promptly resuscitated within one-half to one minute and the patient did not have pre-existing metabolic acidosis, no bicarbonate should be administered until after the first blood gas determination.

Calcium chloride may be useful in asystole and electromechanical dissociation. Calcium ions increase myocardial contractile force, and may enhance ventricular excitability. The primary emergency treatment for asystole and electromechanical dissociation is, of course, ventilation and external cardiac compression. After epinephrine and bicarbonate have been administered, calcium should be given intravenously in a dose of 2.5 - 5 ml of a 10 per cent solution (delivering 3.4 - 6.8 mEq of ionic calcium). The actual dose should be based on the patient's weight. If necessary, the initial dose can be repeated at 10 minute intervals. If administered rapidly, calcium can produce sinus bradycardia or sinus arrest in a beating heart. It can also enhance digitalis toxicity.

Lidocaine is effective in suppressing ventricular ectopic activity and ventricular tachycardia. It should always be administered to a patient following successful defibrillation. An initial bolus loading dose, approximately 1 mg/kg of body weight, should be administered intravenously at a rate no faster than 50 mg/min. Rapid initial infusion rates may produce high transient blood levels that cause central nervous system toxicity, the most serious of which are seizures or respiratory arrest. The bolus can be repeated after 5 or 10 minutes, but the initial loading dose should not exceed 300 mg. Since the distributive half-life of lidocaine is only 9 minutes, the blood level will fall rapidly to sub-

therapeutic levels unless the bolus dose is followed by a continuous infusion. A continuous infusion is usually started at 3 - 4 mg/min (or 50 mcg/kg/min). The elimination half-life of lidocaine is approximately 90 minutes. Therefore with a constant infusion, steady state blood levels are not reached until at least 3½ half-lives, or 5 hours. Until steady state is reached, blood levels continue to rise. With an infusion rate of 4 mg/min. steady state levels may be in the toxic range. As soon as ventricular dysrhythmias are suppressed during a constant infusion, the infusion rate should be tapered to 2 mg/min in order to maintain a therapeutic blood level below the toxic range. Lidocaine is metabolized by the liver, and its volume of distribution is reduced in the presence of heart failure. In patients with liver disease or conditions of decreased liver perfusion (low cardiac output states) and heart failure, both the loading dose and the infusion dose must be decreased. A good rule of thumb is to decrease all doses of lidocaine by one-half in the above conditions. A nomogram is available that allows one to determine the actual doses based upon measured cardiac output.

Post-resuscitative care

Post-resuscitative care includes controlled ventilation with close attention to blood gases and acid base balance; maintenance of cardiac rhythm, blood pressure, and tissue perfusion; preservation of normal organ function; and efforts toward reducing effects of global brain ischemia-anoxia. Preservation of brain function must always remain the primary goal of advanced cardiac life support.

References

[1]American Heart Association: Standards for cardiopulmonary resuscitation (CPR) and emergency cardiac care (ECC) JAMA 227 (suppl 7):833-868, 18 Feb 74.

[2]American Heart Association: A Manual for Instructors of Basic Cardiac Life Support. ed 2. Dallas, American Heart Association, 1977.

[3]American Heart Association: A Manual of Advanced Cardiac Life Support. Dallas, American Heart Association, 1975.

[4]Safar P, Elam JO (eds): Advances in Cardiopulmonary Resuscitation. New York, Springer-Verlag, 1977.

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III. Diagnosis and Treatment of Acute Respiratory Failure

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The rapid onset of dyspnea and tachypnea combined with respiratory alkalosis and arterial hypoxemia is commonly termed acute respiratory failure (ARF). Therapeutic considerations are directed at reversing the difficulties with respiratory gas exchange and at the same time uncovering and treating the underlying cause of ARF.

Etiology

The majority of patients with ARF have suffered damage to pulmonary endothelial or epithelial cells, or both. Aspiration, smoke inhalation, and prolonged exposure to oxygen are all examples of epithelial injury, while fat embolism and septicemia exemplify mechanisms of endothelial cell damage. Pneumonias of various kinds may damage all cell types.

The loss of endothelial cell barrier functions will lead to nonhydrostatic pulmonary edema. This will

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From the Departments of Surgery, Peter Bent Brigham Hospital, and Harvard University School of Medicine, Boston, Massachusetts. Supported in part by the National Institute of General Medical Science, Grant No. GM248901-02; the US Army Medical Research and Development Command, Contract No. DAMD17-78-C-8026; the Brigham Surgical Group, Inc; and the Trauma Research Foundation.

jeopardize respiratory gas exchange as well as increase the work of breathing. Hypoxemia is due in part to an edema induced diffusion barrier, but more importantly to the perfusion of airless, fluid filled, or non-ventilated alveoli. The latter two types of lung pathology can be treated easily by using pressure breathing and raising the resting lung volume or functional residual capacity (FRC). Only modest increases in energy are needed to ventilate fluid filled alveoli compared to ones that are truly airless and atelectatic. Gas filled, but non-ventilated alveoli are due to airway obstruction. Elevation of the FRC will reverse the common problem of critical closure of the small respiratory bronchioles and permit ventilation of these stagnant pockets (Fig. 1).

The other abnormality in respiratory gas exchange is the development of a primary respiratory alkalosis. The stimulus to this hyperventilation is probably mechanical irritation of the interstitial J receptors and C fibers. Simple reversal of hypoxemia will not return p_aCO_2 to normal. Alkalosis of any sort is not desirable because of the secondary changes in serum K^+ as well as the creation of a high oxygen-hemoglobin affinity state.

The major abnormality in respiratory mechanics is the reduced compliance. This requires that more energy be expended for each breath. The increased respiratory frequency, minute ventilation, and enlarged physiologic dead space may severely tax energy reserves. The stiffness of the lungs is in part due to edema, but also may relate to vasoactive agents such as serotonin and histamine, and the reduced alveolar secretion of surfactant. The fall in FRC is a consequence of this fall in compliance as well as the fact that patients are in the recumbent position. This last factor will itself cause a 20 per cent reduction in FRC.

Endothelial cell (EC) barrier disruption: It is likely that an increase in permeability is the usual cause of ARF. However, the sequence of events that leads to EC damage and indeed the anatomic location of the damaged vessels themselves remain obscure. Animal experiments, for example, have demonstrated the extreme vulnerability of the bronchial venules. It is possible that these vessels as well as pulmonary EC can be responsible for pulmonary edema. Thus the intravenous infusion of bradykinin and histamine into experimental animals causes the bronchial venules to leak[9]. The

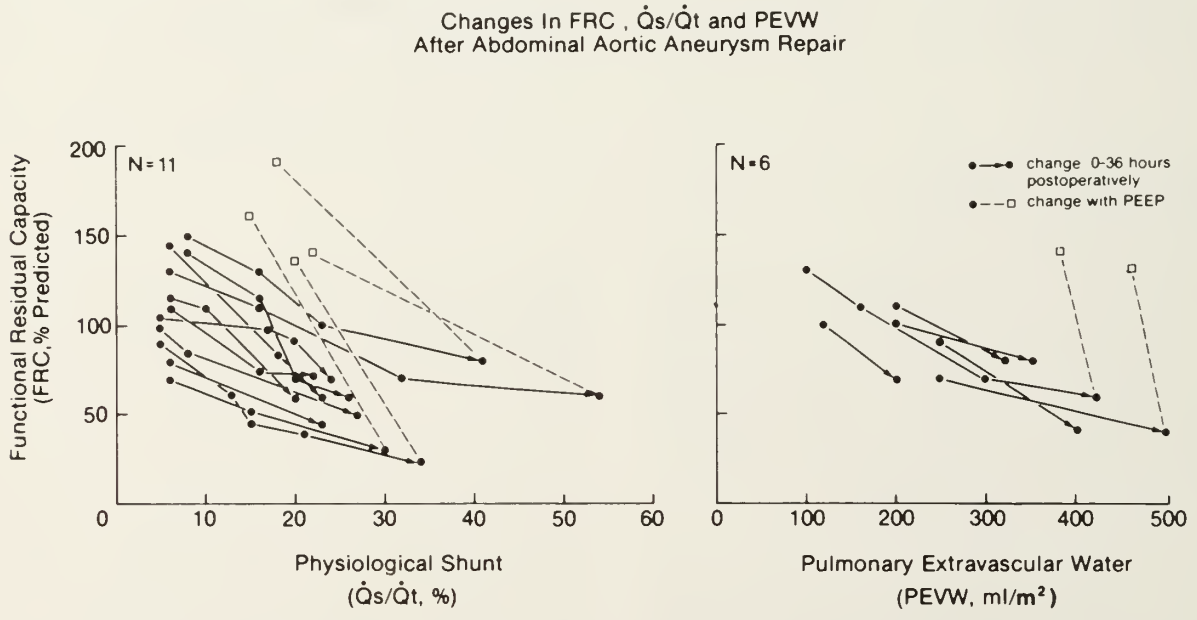

Figure 1. Abdominal aortic aneurysm surgery, particularly when emergency procedures are necessitated by rupture, is frequently complicated by acute respiratory failure. Eleven patients underwent measurements of the FRC and physiologic shunt during 50 per cent oxygen breathing. The line connecting the closed circles indicates the course of a single patient during the first 36 postoperative hours. The arrow shows the sequence of change. There was a relationship between the rise in Q_s/Q_t and decline in FRC. Application of 10 mm H_2O PEEP led to a rapid fall in Q_s/Q_t and rise in FRC. In six of these eleven patients a double tracer technique was used to measure lung water (PEVW). The increase in PEVW from the normal value of 115 ml/m² body surface area probably was related to a decline in compliance which in turn led to a fall in FRC.

mechanism of leakage probably relates to cell shortening due to contractile proteins. This in turn will open intercellular gap junctions and increase permeability. Interestingly, serotonin causes cell contraction but no change in permeability. There are other agents which will induce relatively specific damage to the pulmonary EC. The fact that circulating agents have been found which can mediate ARF does not necessarily identify which agents are causative but does allow an understanding of how non-thoracic trauma and illness can lead to respiratory distress.

Intravascular coagulopathies: A large literature exists regarding intravascular coagulopathies and their etiologic role in ARF. Platelets and white cells may be entrapped in the lungs of animals and man[2,3]. Their interaction with damaged EC, however, does not prove that they have been operative in inducing damage. Indeed, it is difficult to establish even a temporal relationship between either platelet or granulocyte entrapment and any aspect of pulmonary dysfunction.

Microaggregates are known to form in blood. The transfusion of large volumes of liquid stored blood is likely to lead to entrapment of these aggregates in the pulmonary capillary bed. A previous retrospective study of patients who received from 3 to 32 units of blood during emergency abdominal aortic aneurysm surgery for rupture showed that there was no relationship between the volume of transfused blood and the subsequent physiologic shunt. A prospective double blind randomized study comparing the use of washed with unwashed transfused red cells demonstrated no difference in pulmonary function between the two groups. The whole blood group showed no tendency for increase in pulmonary vascular resistance, effective dynamic compliance, or physiologic shunting.

It is possible that microaggregates form in vivo in regions that have been traumatized, and then embolize to the lungs. A perfect setting for such an event is during abdominal aortic aneurysm surgery. The ischemic lower torso is thought to shower the lungs with microemboli after clamp removal[10]. However, we have been unable to document the presence of microaggregates by Coulter counting in the venous blood of these patients, nor have we found that clamp removal induces shunting or increases in pulmonary vascular resistance. As further evidence, the fact that most pathologists fail to find intravascular clot in the lungs of patients dying with ARF strongly argues against aggregates playing an important etiologic role. On the other hand, it is possible that intrapulmonary fibrinolytic events prevent the histologic demonstration of clot. The pulmonary EC will secrete plasminogen activator into blood actively and thereby increase fibrinolytic activity[8].

Local or systemic clotting, or both, and fibrinolysis are considered by some as important causal events of ARF. Trauma can lead to the release of thromboplastic materials and trigger disseminated intravascular coagulation. There is little information however to support the primacy of these events in producing ARF. Thus infrarenal aortic clamping during elective aneurysmectomy has been found to lead to intrapulmonary clotting and fibrinolysis. Intrapulmonary clotting is manifested by a fall in fibrinogen during passage of blood through the lungs and the appearance of soluble fibrin monomer. Fibrinolysis is evidenced by a decline in plasminogen across the lungs and the appearance of fibrin degradation products in concentrations as high as those seen in severe sepsis. These dramatic hematologic events were not related to the volume of blood transfused nor to whether the red cells had been washed. Further, none of 13 study patients developed ARF and there were no correlations between clotting and fibrinolysis and cardio-pulmonary function.

Sepsis: The most common clinical event leading to ARF is sepsis[11]. If sepsis is defined as hypotension and bacteremia, then approximately 70 per cent of surgical patients with this problem will develop flagrant ARF. Conversely, 70 per cent of those surgical patients noted to have ARF will eventually be proven to have a severe infection. In 40 per cent of this latter group the diagnosis of sepsis becomes clear only in the ensuing days, ARF being a presenting sign. The signs and symptoms of severe infection may be obscure, and respiratory failure as well as the failure of other organs should strongly suggest the possibility of sepsis.

The vast majority of infections associated with ARF are infradiaphragmatic in location and are related to leaking bowel, biliary, or urinary anastamoses; to infected hematomas; to frank collections of pus; or to ascending infections of the biliary and urinary tract. The findings of patchy areas of pneumonia by chest x-ray study and positive sputum cultures are common and should not modify an intensive infradiaphragmatic search for infection.

The other increasingly common sites of infection relate to vascular prosthetics and central venous catheters. The latter problem is easily remedied, while the former usually requires a major operative excision.

There is no unique bacterium which is causative.

Over 15 species have been identified. These are mostly gram negative, but gram positive cocci from intravascular catheters have gained in importance.

Non-bacterial events which are prominent in inducing non-hydrostatic pulmonary edema include pancreatitis, infarcted bowel (mucosal or full thickness), and aspiration. Trauma is an event often considered to cause ARF. There is no question that certain unique forms of trauma will induce respiratory failure, such as blast injury and bone fracture with pulmonary fat embolism. However, many examples of trauma induced by ARF are confused by simultaneously occurring non-thoracic and thoracic injury. Thus, patients may truly suffer ventilatory rather than respiratory failure. The signs, symptoms, and blood gas findings in tracheobronchial obstructions or pulmonary parenchymal displacements are similar to those found in ARF. Such pathology is noteworthy and requires prompt therapy, but is not related to EC damage. Other events which may mimick ARF need not be clinically apparent. Head trauma, for example, may produce an extreme but transient sympathetic discharge with systemic hypertension and left ventricular failure. Pulmonary edema may result from this brief episode.

Hemorrhagic hypotension has often been described as a major factor leading to ARF. This has been neither our clinical or experimental experience. In animal studies hemorrhage has been produced in baboons, rhesus monkeys, and dogs. Blood loss and reinfusion were unrelated to pulmonary pathology. It is entirely possible that some of the previous observations in hypotensive patients have simply overemphasized the finding of a low p_aO_2. The low flow state accompanying severe hemorrhage may often cause a marked fall in the venous oxygen tension, which may in turn lead to a lowering of arterial tension. The lungs themselves are normal both histologically and functionally.

Metabolic functions of the EC: In the first few hours after the injection of live E coli into animals, there is no morphologic evidence of lung damage. Functional abnormalities, however, may be striking and equivalent to those seen following exposure to grossly destructive agents such as oleic acid[2]. These types of experimental data illustrate the importance of vasoactive agents in inducing ARF.

Pulmonary blood embolization is a good example of an event which stimulates a neural reflex or causes the release of a vasoactive agent, which in turn constricts bronchial smooth muscle in a region remote from the site of embolization. A variety of agents are capable of producing abnormalities in the V_A/Q relationship. Prostaglandin F_{2a} is an intense bronchoconstrictor and may be produced by pulmonary endothelium in response to an embolism. Serotonin is another agent which acts on smooth muscle. Its actions may lead to severe pulmonary dysfunction. Intravenous serotonin can produce bronchoconstriction as well as loss of alveolar air volume and reduction in the FRC[1]. The latter effect may be mediated by the contractile proteins of endothelial and epithelial cells.

Serotonin is normally concentrated by platelets, which serve to transport this active amine around the body. Capillary EC will also concentrate serotonin, which is then either stored or metabolized by monoamine oxidases. Platelets and EC compete for free plasma serotonin. When excess plasma serotonin is present, over 80 per cent can be cleared by EC. In animal experiments the induction of pulmonary damage by pump perfusion decreased EC clearance[12]. In the setting of these animal experiments, when the physiologic shunt fraction exceeded 20 per cent, serotonin was no longer taken up by the lung EC.

Septic patients have normal whole blood and platelet serotonin concentrations. However, since these patients are thrombocytopenic, free plasma serotonin is increased by three- to four fold. The pulmonary EC clears only 20 to 25 per cent of this plasma serotonin, and arterial plasma levels remain high. The systemic consequences of these increased amine concentrations remain conjectural. Further, it is unknown whether serotonin is responsible, even in part, for abnormalities in the respiratory gas exchange of patients with ARF.

An amazing variety of peptides, lipids, and amines are processed by the metabolic machinery of the pulmonary EC. The local pulmonary and more distant systemic consequences of disorders in the EC function are currently being investigated and it is hoped will be unraveled[5,6,8].

Diagnosis

Most of the signs and symptoms of ARF are nonspecific. The complaint of dyspnea should arouse suspicion. The average respiratory rate is 35, not much higher than the rate of 29 which is the average of patients one day after cholecystectomy. Auscultation and chest x-ray examination are usually not diagnostic.

The chest x-ray film in particular must be viewed with caution[4]. The vast majority of patients with ARF are too ill to be sent to radiology, and the technically inferior portable technique is required. The x-ray estimate of lung water may be grossly in error, since this is a function of the ratio of air to fluid. As the FRC falls, or patients become too ill to take a

deep breath, lung water becomes more prominent. The radiologic findings of diffuse edema are significant. A negative study does not exclude ARF.

If the patient is found to have pulmonary edema, the next critical question relates to his volume status and left ventricular function. Neither the central venous pressure (CVP) nor the portable chest x-ray film can resolve these issues. The CVP is a very poor index of left atrial or pulmonary arterial wedge pressure (PAWP)[7]. Cardiac size cannot be well estimated on a portable x-ray film and grievous errors may result from accepting a radiologic diagnosis of congestive heart failure[4].

A secure diagnosis of non-hydrostatic pulmonary edema can be made only by passing a pulmonary arterial catheter and measuring the PAWP. In seriously ill, nutritionally depleted patients a PAWP greater than 20 mm Hg is indicative of hydrostatic edema. In such patients serum albumin and colloid osmotic pressure tend to be low.

Most patients do not require pulmonary arterial catheterization. Usually, an educated estimate of fluid status may be made by examining changes in body weight and the recorded intake and output. Secondly, it is often appropriate to give the patient a brief 30 to 60 minute trial of a diuretic and a rapid acting inotrope. If information from these maneuvers does not clarify the cardiac status, then pulmonary catheterization is in order.

Arterial blood gases should be obtained early, ideally prior to the institution of therapy. The classic findings are hypoxia, hypocarbia, and an elevated pH due to a primary respiratory alkalosis. Carbon dioxide retention indicates hypoventilation. In this setting the p_aO_2 may be normal if supplemental oxygen is being breathed. The causes of hypoventilation are many, one of which is fatigue brought about by the large work requirements of ARF.

Therapy

The use of increased concentrations of inspired oxygen and, when necessary, intubation and mechanical ventilation have virtually eliminated death from arterial hypoxemia. Many patients will still have major problems with oxygen transport, the most prominent being low cardiac output. In the setting where there is hemodynamic instability, for example hypotension, or a question of proper perfusion, such as stupor, low urine flow, and mottled skin, pulmonary arterial catheterization is recommended. If the p_aO_2 exceeds 50 mm Hg, the ventilator and Pulmonary End Expiratory Pressure, (PEEP) setting are then adjusted such that thermodilution measured cardiac output is maximum. Raising the p_aO_2 above 50 mm Hg (83 per cent saturation) will not add much more oxygen to blood. However, the misguided application of excessive pressure breathing can dramatically impair flow[5] as well as its distribution[6].

These patients cannot be treated by dehydration. This yields little pulmonary advantage and causes the cardiovascular system to be unstable. Approximately one half of these patients have a peak cardiac output when the PAWP is maintained between 10 to 12 mm Hg. The other patients have a continually rising CO_2 even at a higher PAWP. It is our current practice to infuse volume until a satisfactory flow is achieved (greater than 4.0 $L/min \cdot m^2$) or until a PAWP of 10 to 12 mm Hg is reached.

Causative factors: A diligent search must be made for the underlying cause of ARF. Unless this is found and corrected, the prognosis is grim. The postoperative or traumatized surgical patient with ARF must be suspected of harboring a septic focus. Transient improvement with antibiotic, fluid, and ventilator management is typical, but should not lead to complacency. Failure to find a cause of ARF, and evidence of infection may well necessitate a blind exploration of the abdomen. Little doubt exists regarding the favorable outcome in patients in whom a treatable septic focus is found.

Summary

Acute respiratory failure is characterized by changes in the barrier or metabolic functions of lung endothelium, or both. The former event leads to pulmonary edema and stiff lungs, while severe abnormalities in respiratory gas exchange may accompany both an increase in endothelial permeability as well as a change in metabolism. Clinical signs and symptoms may not be specific. The same is true of laboratory data such as arterial blood gases and the portable chest x-ray film. Pulmonary arterial catheterization may be needed to exclude the possibility of left ventricular failure and hydrostatic pulmonary edema. Therapeutic considerations involve endotracheal intubation and the use of pressure breathing. Ventilatory management must attempt to optimize oxygen availability rather than simply focusing on the p_aO_2. Finally, since 70 per cent of surgical patients who develop respiratory failure have an infradiaphragmatic source of sepsis, an exhaustive search for such a focus must be conducted and vigorous therapy instituted, which frequently is surgical exploration and drainage.

References

[1]Colebatch HJ, Olsen CR, Nadel JA: Effect of histamine, serotonin, and acetylcholine on the peripheral airways. J Appl Physiol 21:217-226, Jan 66.

[2]Hechtman HB, Lonergan EA, Staunton HP, Dennis RC, Shepro D: Pulmonary entrapment of platelets during acute respiratory failure. Surgery 83:277-283, Mar 78.

[3]Hechtman HB, Lonergan EA, Shepro D: Platelet and leukocyte lung interactions in patients with respiratory failure. Surgery 83:155-163, Feb 78.

[4]Liebman PR, Philips E, Weisel R, Ali J, Hechtman HB: Limitations of portable roentgenography of the chest in patients with acute respiratory failure. Surg Gynecol Obstet 146:705-708, May 78.

[5]Manny J, Grindlinger G, Mathe AA, Hechtman HB: Positive end-expiratory pressure, lung stretch and decreased myocardial contractility. Surgery 84:127-133, Jul 78.

[6]Manny J, Justice RE, Hechtman HB: Abnormalities in organ blood flow and its distribution during PEEP. Surgery, to be published.

[7]Manny J, Grindlinger GA, Dennis RC, et al: Myocardial performance curves as a guide to volume therapy. Surg Gynecol Obstet 149:863-873, Dec 79.

[8]McLoughlin GA, Grindlinger GA, Hechtman HB. Induction of fibrinolytic activity by pressure breathing. Surg Forum 29:201-203, 1978.

[9]Pietra GG, Szidon JP, Leventhal MM, et al: Histamine and interstitial pulmonary edema in the dog. Circ Res 29:323-337, Oct 71.

[10]Stallone RJ, Lim RC, Blaisdell FW: Pathogenesis of the pulmonary changes following ischemia of the lower extremities. Ann Thorac Surg 7:539-549, Jun 69.

[11]Vito L, Dennis RC, Weisel RD, et al: Sepsis presenting as acute respiratory insufficiency. Surg Gynecol Obstet 138:896-900, Jun 74.

[12]White MK, Hechtman HB, Shepro D: Canine lung uptake of plasma and platelet serotonin. Microvasc Res 9:230-241, Mar 75.

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IV. An Evaluation of Intra-Abdominal Injuries

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Most intra-abdominal injuries are caused by either blunt or penetrating abdominal trauma. Blunt trauma accounts for about two-thirds of significant abdominal trauma, although the incidence of penetrating trauma is increasing, especially gunshot wounds. Automobile accidents account for two-thirds of blunt injuries; and one-third of these involve pedestrians, over half of whom are children. Direct blows to the abdomen account for 20 per cent and falls or freak accidents account for 10 per cent of blunt abdominal trauma.

Efficient and proper evaluation in treating patients with abdominal trauma requires an organized approach. Attention to the A B Cs of resuscitation is essential. Following resuscitation, a good history and physical examination are preliminary to further investigation.

A proper history should include information about alcohol or drug intake and anticoagulant, aspirin, or steroid use. Presenting complaints give clues to underlying injuries. Pain in the left shoulder following abdominal trauma (Kehr sign) suggests splenic injury. Right upper quadrant pain suggests liver injury.

If seatbelts were worn, abdominal injury is possible even without direct trauma to the abdomen. Reported "seatbelt injuries" include ruptured aorta, ileal hematoma and perforation, duodenal perforation, pancreatic rupture, bladder contusion, and, abdominal wall hematoma. If worn improperly, that is, above the pelvic brim, the belt can cause a ruptured spleen, jejunal perforation, rectus hematoma, mesenteric root injury, and perforated gravid uterus. Rib fractures and chest contusions can occur with the harness type restraint, and these are associated with splenic and liver injuries.

The mechanism of "seatbelt injuries" involves a crushing of intestinal loops between the abdominal wall and vertebrae. If the intraluminal pressure exceeds bowel elasticity, perforation will occur longitudinally. Also, deceleration forces create shearing stresses between anchored and free points in the peritoneal and thoracic cavities.[1]

Impact or compression trauma causes damage more often to solid organs of the abdomen such as the spleen and liver. These two organs are injured 50 to 75 per cent of the time following blunt

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impact.[2-5] Explosions can perforate the rectum and colon by increased atmospheric pressure. However, these are rare injuries outside of battlefield conditions.

Evaluation of Blunt Abdominal Injury

The initial vital signs, level of consciousness, and the physical findings determine the steps to be taken in evaluating the patient following blunt abdominal trauma. A patient who is hypotensive, requiring massive volume transfusion, and presents with a distended and rigid abdomen must be prepared for the operating room as quickly as possible. However, at the other extreme are patients who are entirely asymptomatic following blunt trauma to the abdomen. These account for about 40 per cent of patients suffering blunt abdominal trauma. About one-third of these patients have a significant intra-abdominal injury eventually requiring surgery.[6]

Peritoneal signs may not be present on the initial evaluation in the emergency room. Hemoperitoneum is innocuous unless compounded by free bile, gastric juice, or pancreatic juice. Abdominal tenderness, rigidity, and guarding reflect peritoneal irritation or inflammation leading to adynamic ileus and absent bowel sounds. This usually takes time to develop, which accounts for the large number of normal physical examinations recorded initially on patients with significant intra-abdominal injury. A drunk or narcotized patient or a patient with a brain injury is even more difficult to evaluate, using physical findings only, because of the suppressing effect of these conditions.

If the patient is stable, x-ray studies should quickly follow the physical examination. The chest x-ray film should be taken in an upright position to detect signs of intrathoracic injury, such as widening of the mediastinum, pleural effusion, or pneumothorax. Free air under the diaphragm may be present with as little as 1 ml of free air in the peritoneal cavity. A left lateral decubitus x-ray film of the abdomen will show the free air concentrated along the right lobe of the liver, thus maximizing the chances of its being demonstrated. Concurrent with the x-ray studies, a complete blood count, blood urea nitrogen determination, amylase determination and urinalysis are obtained in addition to typing and cross-matching of the patient for transfusion. If hematuria is present or if suspicion is high, an intravenous pyelogram should be obtained before abdominal exploration in order to demonstrate both kidneys.

Since the initial physical examination studies following blunt abdominal trauma are not always reliable, that is, since there are a significant number of false negative and false positive findings, peritoneal lavage should be carried out early to rule out significant but undetected intra-abdominal injury. It is important to emphasize that this should be done following a thorough physical examination and initial x-ray studies on a stable patient. This examination is especially helpful in the unconscious patient or in the patient who needs to have major surgery for something other than an intra-abdominal injury. Table 1 reviews the indications for abdominal lavage. Patients obviously requiring abdominal exploration because of hypotension and physical findings do not require lavage. Patients who have had previous abdominal surgery should not be lavaged, because of the danger of perforating a viscus and because loculation of the lavage fluid not communicating with the rest of the peritoneum may give a false negative finding. Neither should a pregnant woman be lavaged because of the danger of perforating the uterus. Some have advocated that in these situations the lavage be performed to the right or left of the rectus muscles, but this increases the risk of injury. Penetrating wounds of the abdomen are a relative contraindication because the presence of blood in the pertioneal cavity from penetrating wounds does not necessarily correlate with the presence of significant intra-abdominal injury.

Table 1. Indications for Peritoneal Lavage

The Unconscious Patient
The Patient Needing Surgery for Non-Abdominal Injuries
A History of Significant Blunt or Deceleration Injuries
The Patient with Abdominal Wall Abrasions, or Fractured Pelvis, or Fractured Ribs
A High Index of Suspicion

Table 2 is a summary of a review of the recent literature verifying the accuracy of peritoneal lavage. The major criticism is that lavage may be too sensitive. Olsen[2] has shown that only 8 drops of blood in one liter of lavage fluid will give a trace positive result. Using a quantitative visual method, he was able to refine his analysis of the lavage effluent and avoid many negative laparotomies. He assessed the effluent as negative or trace to 5+ positive. In 98 per cent of patients with a 3+ or greater lavage finding, a significant intra-abdominal injury was found. Only 32 per cent of patients with a trace to 2+ lavage had a significant

Table 2. Results of Peritoneal Lavage

Author	Percent of Patients Lavaged with Significant Intra-Abdominal Injuries		
	Positive Lavage		Negative
Root '70		96%	0%
Thal '72		95%	0.6%
Olsen '72	(3 to 5 +)	98%	0%
	(2 +)	47%	
	(1 +)	13%	
	(Trace)	0	
Perry '72		98%	0.2%
Gill '75		99%	0.3%
Parvin '75	(Strongly + 'VE)	94%	0%
	(Weakly + 'VE)	9%	
Drew '77		99%	0.4%
Sloop '78		94%	0%

intra-abdominal injury. No patient with a negative lavage finding had a significant intra-abdominal injury. A 2+ fluid is sufficiently clear to allow newsprint to be read through it, while this cannot be done for a 3+ or greater finding. Parvin[3] divided the lavage effluent into negative, weakly positive (trace to 2+), or strongly positive (3+ to 5+), depending on the ability to read newsprint through the effluent. All patients with strongly positive findings were operated upon, and 94 per cent of these were found to have significant intra-abdominal injuries. Those patients with weakly positive findings were studied further by echography and arteriography. Only 9 per cent of these patients had significant intra-abdominal injury. Using this approach, the rate of negative findings on laparotomy was only 10 per cent. In this series there were no false negative lavages.

Doing red blood cell and white blood cell counts of the lavage effluent is time-consuming and unnecessary. Also, the correlation with injury is not as good as with the visual newsprint method. The effluent should be evaluated for bile, bacteria, and amylase, but their presence should not be the sole criterion for exploration. Paracentesis should not be carried out, because, in most series, there is only a 20 to 30 per cent correlation with the presence or absense of significant intra-abdominal injury. Ultrasound, liver-spleen scan, intravenous pyelogram, aortogram, and Gastrografin® studies are necessary in evaluating the stable patient with weakly positive lavage.

Ultrasound study of the spleen is helpful when normal because of the low rate of false negatives. However, abnormal ultrasound correlates with the presence of significant abdominal injury only in a minority of cases (15 per cent).[3] Liver-spleen scan is much more helpful. Witek[7] reports in his search of the literature that there has been only one case reported of a ruptured spleen and a normal spleen scan. Also, there has never been a case where arteriography detected a splenic rupture missed on scan. The defects noted on scan are capsular distortion and blurring and filling defects of the splenic pulp. If a spleen scan is normal, no further studies are necessary to rule out spleen injury. If the scan is abnormal and if there is still doubt about the presence of a splenic rupture, arteriography is then necessary.

Arteriography is occasionally helpful in locating the source of intra-abdominal bleeding in a stable patient. It has been used mainly in detecting splenic injury, renal trauma, and renal artery tears, in localizing the bleeding point in liver laceration; and in localizing and controlling pelvic bleeding following fractures. It is by no means a routine test.

To demonstrate visceral tears, such as retroperitoneal duodenal tears, injection of air or Gastrografin®, or both through a nasogastric tube will produce extravasation of dye and air. Barium should not be used because of the danger of barium peritonitis.

Hyperamylasemia is usually not an indication of pancreatic injury. Olsen[8] reports that only 8 per cent of patients with hyperamylasemia following blunt abdominal trauma had pancreatic injury, while 66 per cent had a significant intra-abdominal injury and all had positive peritoneal lavage findings. Most had spleen and visceral injuries. All hyperamylasemia findings without associated significant injury resolved within 24 hours. In contrast, hyperamylasemia associated with significant abdominal injury occurred 12 to 24 hours later.

Evaluation of Penetrating Abdominal Injury

It is important to remember that any penetrating injury from the nipples to the gluteal crease may penetrate the abdomen. Some 25 per cent of all penetrating abdominal wounds also involve the thoracic cavity.[9] The organs most commonly injured vary from those affected by blunt trauma. There is a more even distribution of injury ranging from the liver at 23 per cent, small intestine 21 per cent, colon 15 per cent, to the stomach at 13 per cent. Injuries to all other structures constitute less than 10 per cent of the total.

In examining a patient with a penetrating abdominal wound, locating the entrance and exit

wounds will help identify the trajectory or direction of penetration. Probing of wounds or sinograms are to be avoided, because of the high frequency of false negative examinations and because of their interference with the interpretation of physical findings if the patient is to be observed.

The demonstration of peritoneal penetration by stab wounds does not signify that laparotomy is indicated. About one-third of stab wounds do not penetrate the abdomen, and less than 50 per cent of those that penetrate the peritoneum require surgery. Therefore, mandatory exploration for all stab wounds would result in too many with negative findings. If there is evidence of visceral injury, such as pneumoperitoneum or peritonitis with fever, or if there is unexplained hypotension or evisceration, laparotomy should be performed. Otherwise, observation is the management of choice in a stable stabbing victim. Delay until signs of injury present produces no significant sequelae. With this approach, frequent physical examinations by the same observer will eventually disclose all patients requiring surgery. Once it is decided that a visceral injury has occurred and that surgery is necessary, treatment with prophylactic antibiotics should be initiated. The current choices are Cleocin® and gentamicin.

All abdominal gunshot wounds should be explored, unless the wound is obviously tangential to the peritoneal cavity. Using this approach, the frequency of false negative findings in laparotomy for gunshot wounds is about 20 per cent. Penetration of the peritoneal cavity by a bullet is associated with visceral injury in 98 per cent of cases. There has never been a case reported of significant intra-abdominal injury in which the bullet did not penetrate the peritoneum.

Mandatory exploration for all stab and gunshot wounds at Harlem Hospital resulted in negative findings in 40 per cent of cases of stab wounds and in 21 per cent of cases of gunshot wounds.[10] The morbidity following laparotomy with negative findings was 8 per cent, due mostly to pulmonary problems. At Charity Hospital in New Orleans, careful observation of stab wounds, led to a reduction of negative findings at laparotomy to 11 per cent.[11] Most importantly, there was no increased morbidity from the delay due to observation in patients with significant intra-abdominal injuries. Mandatory exploration of gunshot wounds of the abdomen results in a 13 per cent rate of negative laparotomy findings. Using a selective approach to both stab and gunshot wounds, McAlvanah[12] at Kings County Hospital in Brooklyn, explored only 29 per cent of the stab wound cases and 54 per cent of the gunshot wound cases. Negative findings at laparotomy were encountered in 20 per cent of stab wound cases and in only 4 per cent of gunshot wound cases. There was no morbidity or mortality associated with the explorations producing negative results.

Peritoneal lavage in all penetrating wounds of the abdomen is unnecessary. Its main value is in ruling out simultaneous abdominal injury in penetrating chest sounds. Peritoneoscopy is of uncertain value in stable patients with blunt or penetrating trauma. Laparotomy can be avoided in 60 per cent of patients using this procedure.[1] There can be some false positive examinations, but there have been no false negatives. Experience with this technique in trauma situations has been limited, but generally those patients not subjected to laparotomy could probably have been spared laparotomy just as well by close observation.

Therefore, for the present peritoneoscopy in abdominal trauma patients must be considered to be of dubious value.

References

[1]Witte CL: Mesentery and bowel injury from automotive seat belts. Ann Surg 167:486-492, Apr 68.

[2]Olsen WR, Redman HC, Hildreth DH: Quantitative peritoneal lavage in blunt abdominal trauma. Arch Surg 104:536-543, Apr 72.

[3]Parvin S, Smith DE, Asher WM, et al. Effectiveness of peritoneal lavage in blunt abdominal trauma. Ann Surg 181:255-261, Mar 75.

[4]Gill W, Champion HR, Long WB, et al: Abdominal lavage in blunt trauma. Br J Surg 62:121-124, Feb 75.

[5]Davis JJ, Cohn I, Nance FC: Diagnosis and management of blunt abdominal trauma. Ann Surg 183:672-677, Jun 76.

[6]Jergens ME: Peritoneal lavage. Am J Surg 133:365-369, Mar 77.

[7]Witek JT, Spencer RP, Pearson HA, et al: Diagnostic spleen scans in occult splenic injury. J Trauma 14:197-199, Mar 74.

[8]Olsen WR: The serum amylase in blunt abdominal trauma. J Trauma 13:200-204, Mar 73.

[9]Freeark RJ: Penetrating wounds of the abdomen. N Engl J Med 291:185-188, 25 Jul 74.

[10]Forde KA, Ganepola GA: Is mandatory exploration for penetrating abdominal trauma extinct? The morbidity and mortality of negative exploration in a large municipal hospital. J Trauma 14:764-766, Sep 74.

[11]Nance FC, Wennar MH, Johnson LW, et al: Surgical judgment in management of penetrating wounds of the abdomen: Experience with 2212 patients. Ann Surg 179:639-646, May 74.

[12]McAlvanah MJ, Shaftan GW: Selective conservatism in penetrating abdominal wounds: A continuing reappraisal. J Trauma 18:206-212, Mar 78.

[13]Carnevale N, Baron N, Delany HM: Peritoneoscopy as an aid in the diagnosis of abdominal trauma: A preliminary report. J Trauma 17:634-641, Aug 77.

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V. Emergency Care of Chest Injuries

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Injuries involving the chest demand immediate attention, even in the instance of an apparently innocuous insult. Precipitous death can follow laceration of the lung, great vessels, or heart, but early and appropriate intervention can lead to dramatic physiologic improvement and salvage of many severely ill and compromised patients.

Cardiac injuries cannot be addressed without a complete understanding of the heart's surrounding mesothelial envelope, the pericardium. This tough elastic structure surrounds the heart and proximal few centimeters of the great vessels. Its continued integrity, seen in most blunt cardiac injuries, may contain any blood leaking from the cardiac chambers, thereby allowing the patient to reach the Emergency Unit in a resuscitatable condition. Small penetrating wounds, such as knife, ice pick, and small caliber missile injuries, are also compatible with containment of blood inside the pericardium.

The accumulation of blood, or any fluid, in the pericardial sac leads to a rise in the pressure in the pericardium after a certain amount of fluid is collected — that quantity which exceeds the ability of the sac to stretch or accept any more volume. The quantity of fluid required to raise the pericardial pressure will vary, depending upon the rapidity with which it accumulates and the compliance of the pericardial sac itself. As the pressure in the pericardium rises, severe cardiovascular effects occur, causing circulatory embarrassment and, ultimately, death. Pericardial tamponade severely restricts ventricular filling by not allowing diastolic expansion of the chamber, leading to increased venous pressure, tachycardia, and reduced stroke volume.

Tamponade presents the following clinical picture: 1. elevated central venous pressure, 2. tachycardia, 3. thready pulse, 4. (probable) hypotension, 5. pulse paradoxus, 6. Kussmaul's sign, and 7. possible reduced heart sounds.

Pulsus paradoxus is a decline of more than 10 mm Hg in the systolic arterial pressure on spontaneous inspiration. This is caused by decreased left ventricular filling and stroke volume associated with a fall in pulmonary venous return on inspiration. Kussmaul's sign is a rise in jugular venous pressure with inspiration, caused by a *reduction* in venous return to the right atrium/ventricle with inspiration.

Pericardial tamponade demands immediate therapy, for the accumulation of even a small additional amount of blood in the pericardium may lead to irreversible cardiac compromise. The easiest and fastest method of treatment is to remove fluid from the pericardial space. While preparations are being made for this procedure (pericardiocentesis), large volumes of intravenous infusions should be administered, for, by increasing venticular filling pressures through raising the venous pressure, stroke volume may be increased. Pericardiocentesis, however, should be performed immediately. It is most safely carried out through the subxyphoid approach with a large 13-gauge needle sheathed over a long 20-gauge spinal needle. This method is not as absolutely safe as is electrocardiographic monitoring of the exploring pericardiocentesis needle, but the latter maneuver takes more time to prepare, with sterile alligator leads connecting the needle to the precordial lead of the electrocardiograph. When the pericardial space is entered with the thin spinal needle, an event marked by an unmistakable "popping" sensation through the thin, taut, pericardium, the larger needle is advanced over the stylet into the pericardial space and fluid aspirated through it. Dramatic improvement frequently follows the removal of as little as 50 ml of blood, but all possible fluid should be aspirated. A plastic catheter may be passed through the large needle to allow repeated aspirations.

Knife wounds may be treated by pericardiocentesis alone; however, if hemopericardium recurs, immediate thoracotomy is indicated. The presence of hemopericardium secondary to a missile

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injury is an absolute indication for exploratory thoracotomy, although pericardiocentesis may be helpful in resuscitating a moribund patient while preparations are being made for operation.

The most effective emergency operative route to the heart is through an anterior thoracotomy in the left fourth or fifth interspace. This rapidly exposes the pericardium and anterior surface of the heart. Many penetrating injuries of the ventricles can be temporarily controlled in the Emergency Ward through this approach. Definitive repair should be carried out in the operating room following closure of lacerations in the Emergency Ward. Blunt injuries causing hemopericardium will rarely be controllable with the limited facilities and equipment found in most emergency facilities and should be treated in an operating room equipped with cardiopulmonary bypass capabilities.

Most blunt thoracic injuries requiring surgical correction involve the great vessels rather than the heart itself. The thoracic aorta is especially liable to fracture in automobile accidents. As many as 60 per cent of deaths secondary to road traffic accidents are due to rupture of the thoracic aorta.[1] Most of the patients so involved will not reach a hospital; but, in the few whose adventitia is tenacious enough to maintain some integrity of aortic continuity, the presence of mediastinal widening on a plain chest roentgenogram mandates immediate aortography to rule out transection of the media and intima of the aorta with the formation of a false aneurysm. Eighty per cent of injuries seen will involve the isthmus of the descending thoracic aorta, immediately past the origin of the subclavian artery. Approximately 20 per cent of injuries will lacerate the ascending aorta, sometimes also causing aortic valvular insufficiency on the basis of dilatation of the annulus and lack of support for one of the valve cusps.

Angiographic demonstration of an aortic transection is usually possible. There are very few false negative aortograms. Operative repair of ascending tears is carried out using classical cardiopulmonary bypass. Descending aortic lesions may be repaired using left heart bypass, a commercially available shunt, or sometimes no bypass device at all.

Rupture and bleeding are the major dangers to life in blunt and penetrating aortic injuries. Rapid infusion of blood and crystalloid is necessary to have any hope of salvaging the patient with such an injury. The most available source of blood for resuscitation is the victim's hemithorax. Use of a commercially available autotransfusion device can provide large volumes of blood for transfusion.[2] In the absence of these products, aspiration of blood from an intercostal catheter into a sterile vacuum bottle, which can then be used as a blood administration bottle, is possible and easily fashioned.[3, 4]

In the resuscitation of patients with thoracic injuries, one must be continually vigilant *not* to use the ipsilateral brachiocephalic venous system as an access route. Lacerations of the subclavian veins can easily occur in thoracic injuries, and it does little good to keep transfusing a hemithorax through a subclavian venous rent. Special care should be taken, therefore, to use only the contralateral brachiocephalic venous system in unilateral thoracic injuries, and the saphenous/inferior vena cava system in bilateral thoracic injuries, if possible.

Chest injuries are frequently associated with the accumulation of air, as well as blood, in the thoracic cavity (pneumothorax). This is almost always caused by a lung laceration with escape of air into the pleural space from the pulmonary parenchyma. Air in the chest cavity is detrimental for several reasons. It can cause collapse of the lung and its resultant hypoxemia and hypercarbia; it can prevent full expansion of the lung, thereby precluding apposition of the parietal and visceral pleurae; and, if air accumulates in the hemithorax under high pressure by continual one-way entry from the lung via a flap-valve mechanism, a tension pneumothorax occurs. This pushes the mediastinal structures to the contralateral side and can be lethal. Tension pneumothorax is characterized by respiratory distress, cardiovascular compromise, absent breath sounds over a hyperresonant hemithorax, and deviation of the trachea to the opposite side. A tension pneumothorax must be treated immediately. This is most easily accomplished by plunging a large bore needle or a knife blade into the pleural space as soon as the diagnosis is made. A chest tube should then be placed to continue to drain the air from the chest in a controlled fashion.

Chest tubes are most safely inserted by sliding the catheter over the top of the lower rib in the interspace used. Classically, tubes are inserted anteriorly in the second intercostal space in the midclavicular line for a pneumothorax, and posteriorly behind the midaxillary line in the sixth or seventh intercostal space for blood or other fluid in the chest. Chest tubes should never be clamped in the face of an air leak or active bleeding, for this may cause redevelopment of a tension pneumothorax or at least the collapse of the lung under the pressure of accumlating air or blood. It also cuts off access to the potentially re-transfusable shed blood in the hemothorax and removes a monitor of ongoing intrathoracic bleeding, an indicator of whether/when to operate.

Blunt thoracic injuries are also at times associated with instability of the thoracic wall. In order to ensure satisfactory ventilation and oxygenation in the injured patient, the mechanical function of the ribs and diaphragm must either be guaranteed to be intact or be replaced with artificial positive-pressure ventilation. All defects in the chest wall must be closed. This can usually be effected by the placement of an occlusive dressing in the Emergency Ward. Sometimes the addition of vaseline gauze may help. Severe instability of the chest wall, involving double fractures of several contiguous ribs, is called "flail chest". This is always associated with an underlying pulmonary contusion. This parenchymal injury frequently leads to the hypoxic complication of such severe chest trauma. Trinkle's approach to "flail chest", vigorous diuresis and chest physical therapy, has become more commonly accepted,[5] although there has been a recent resurgence of interest in operative internal fixation of the rib fractures.[6] Correct treatment of this lesion remains controversial.[7]

Physicians caring for patients with major thoracic injuries are faced with the major decision of whether or not to perform a thoracotomy, and where to place it. Indications will vary, but most thoracic surgeons would agree that the following constitute sufficient reasons for exploration of the chest: (1) continued hemorrhage after expansion of the lung, (2) continued major air leak with recurrent tension pneumothorax, (3) diaphragmatic injury with translocation of abdominal viscera into the chest, (4) injury to mediastinal structures, the esophagus and aorta, (5) fractures or lacerations of the trachea or bronchi, and (6) the presence of large foreign bodies. Foreign bodies, such as large butcher knives, should not be removed in the Emergency Ward. Rather the patient should be taken to the operating room, and the foreign body removed under sterile operating conditions.

Most patients with major thoracic injuries who arrive alive in an Emergency Ward should be salvaged. Close attention and familiarity with the physiological principles of pericardial tamponade, tension pneumothorax, and hypovolemic shock and the correct aggressive Emergency Ward interventions described above will allow the more measured and formal reparative procedures to be performed with a greater chance of a successful outcome.

References

[1]Greendyke RM: Traumatic rupture of the aorta. Special reference to automobile accidents. JAMA 195:527-530, 14 Feb 66.

[2]Bregman D, Parodi EN, Hutchinson JE, et al. Intraoperative autotransfusion during emergency thoracic and elective open-heart surgery. Ann Thorac Surg 18:590-596, Dec 74.

[3]Symbas PN: Autotransfusion from hemothorax: Experimental and clinical studies. J. Trauma 12:689-695, Aug 72.

[4]Moncure AC, McEnany MT: Cardiovascular emergencies, in Wilkins EW (ed): Textbook of Emergency Medicine. Baltimore, William & Wilkens, 1978, p 381.

[5]Trinkle JK, Richardson JD, Franz JL, et al: Management of flail chest without mechanical ventilation. Ann Thorac Surg 19:355-363, Apr 75.

[6]Moore BP: Operative stabilization of non-penetrating chest injuries. J Thorac Cardiovasc Surg 70:619-630, Oct 75.

[7]Moore BP: The management of flail chest, in Williams WG, Smith RE (eds): Trauma of the Chest. Bristol, England, John Wright and Sons, 1977, P 1.

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VI. Management of Peripheral Arterial Trauma

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The vast majority of knowledge concerning arterial trauma has been born from battlefield experience. DeBakey and Simeone,[1] Hughes,[2,3] and Rich[4,5] made invaluable contributions to the vascular surgical literature following World War II, the Korean War, and the Vietnam War respectively. The amputation rate during World War II approached 49 per cent following simple ligation for

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arterial wounds. However, during the Korean Conflict, direct arterial repair was utilized, and the amputation rate fell to 13 per cent. The Vietnam experience was similar with a 13 per cent amputation rate following major arterial injuries, but the higher velocity missiles had produced greater soft tissue injury. Fortunately, the civilian series are more encouraging with a less than 5 per cent amputation rate.

This review will concentrate on specific points which are important in the diagnosis and treatment of arterial injuries, emphasizing the importance of an early accurate diagnosis and expeditious primary treatment.

Classification and Distribution

Vascular injuries may be classified into two large categories; ie penetrating and non-penetrating wounds. The more common penetrating wounds would include missiles and sharp instruments, but also included should be iatrogenic injuries following catheterizations or injections and the intentional injection of illicit drugs. Of the non-penetrating injuries, bony fractures and dislocations are the most common and often present the most difficult diagnostic challenges. The distribution of all types of arterial wounds is strongly weighted toward the extremities both in civilian and military series. The highest percentage of wounds involves the radial, ulnar, brachial, femoral, and popliteal arteries.

Diagnosis

The most important factor in the successful management of arterial trauma is early recognition, which is preceded by a high index of suspicion. Often, the patient has concurrent injuries which may divert the clinician's attention or possibly conceal the arterial wound, such as a popliteal arterial injury associated with a fractured femur. An evaluation of the peripheral circulation must be an early consideration in the management of any trauma victim, and certain guidelines are important.

Obvious signs of major arterial injury include active bleeding or a history of bleeding, a large hematoma, or severe hypotension. Inability to palpate an isolated peripheral pulse in a patient who is not hypotensive is evidence of an arterial injury until proven otherwise. In other words, one should never make the diagnosis of arterial spasm in cases with diminished or absent pulses until arterial injury has been excluded.

In some instances the presence of a bruit is the only sign of a vascular wound, specifically true in cases of acute arteriovenous fistulae. Finally, when penetrating wounds are closely related to major vessels or when one has diagnosed an injury of a juxtaposed nerve structure, associated vascular injuries must be considered, an example being a femoral nerve injury secondary to a gunshot.

The diagnosis of arterial injuries can be confirmed by contrast angiography or surgical exploration, and more recently Moss et al[6] reported on the use of isotope angiography. Contrast angiography has been shown to be quite accurate in the diagnosis of occult vascular injury. Snyder et al[7] found only one false negative study in a series of 177 patients. In addition, angiography can outline the extent and location of complicated injuries such as shotgun pellet wounds and comminuted fractures. Also, in penetrating wounds of the neck, arteriography can determine the feasibility of surgical repair in high carotid lesions. However, angiography is not indicated in all arterial trauma, and one should not delay operative intervention in cases where there is active hemorrhage.

Doppler ultrasonic flow detectors are other useful tools helpful in the early recognition of arterial injuries. Lavenson et al[8] reported upon its use in Vietnam, where they found excellent correlation between the presence of flow detected by the Doppler and the viability of the extremity both before and after surgical therapy. When the problem of infection complicated an arterial injury, adequate Doppler flow findings allowed them to delay arterial repair until after the infection was controlled.

Treatment

Successful management of arterial injuries requires knowledge of vascular surgical technique and proficiency in executing the repair correctly the first time. Technical errors during the first operation often preclude a favorable outcome. Preoperative management includes systemic resuscitation from shock and the control of active bleeding, usually by simple pressure. The injudicious use of clamps in a poorly lighted wound could lead to inadvertant permanent nerve injuries. Antibiotics are recommended in all cases of arterial trauma and in-line monitoring of arterial, venous, and pulmonary capillary wedge pressures is often imperative.

From a technical standpoint, all of the classical rules of surgery apply to arterial wounds. The soft tissue wounds should be debrided of necrotic tissue and irrigated with saline or an antibiotic solution. Care should be taken not to overlook an intimal tear which may extend beyond the external evidence of injury. Debride the vessels of non-viable tissue and

disrupted intima. Avoid anastamoses under tension; and, therefore, anticipate the possible need for a vein graft by planning its exposure preoperatively. Remove arterial thrombi both proximal and distal to the repair. Always provide adequate soft tissue coverage with well-vascularized clean tissue. At the time of arterial repair, manage concurrent nerve and vein injuries, since the success of an arterial repair is often dependent on adequate venous outflow.[9] Finally, operative angiography after the repair can possibly identify a cause of early failure; and, therefore, arteriography is recommended in most cases.

In spite of our ability to anastamose vessels, one should not forget that some injuries are best managed by simple ligation, as described by Brisbin et al.[10] These injuries include: 1) a radial or ulnar artery injury alone at any level; 2) a profunda femoris injury; and 3) an injury of the anterior tibial, posterior tibial, or popliteal artery alone at any level. Also, if the wound is grossly contaminated or infected, simple ligation followed by bypass surgery through a clean operative field using a separate clean operative set-up is recommended.

Specific Problems

There are certain types of injuries which warrant specific comment. Injuries to the carotid arteries can be secondary to either penetrating or blunt trauma, and patients with these injuries may present with or without neurological deficits. Angiography is often necessary to diagnose, as well as define, the extent of the injury. The critical question has always been how to identify those patients who may be made worse by repair of their injured arteries as opposed to simple ligation, the rationale being that revascularization of an ischemic zone may produce a hemorrhagic infarct. Cohen et al[11] noted a significant number of neurological deaths among patients who had had neurological deficits prior to arterial repair. However, Liekweg et al[12] reviewed the current literature and added a series of 18 patients showing that "ligation of the carotid artery is indicated only for the comatose patient without prograde flow and for technical reasons when repair is impossible".

Injuries of the innominate, subclavian, and axillary arteries pose special problems because of operative exposure. The etiology is usually a penetrating wound secondary to either a gunshot or a stab. Massive blood loss and shock are dominant clinical findings, and immediate operation is often necessary. Because of numerous branches originating in this area, standard proximal and distal control is a unique challenge. A supraclavicular incision with subperiosteal resection of the midclavicle provides the best exposure of the distal innominate, subclavian, and axillary vessels. This incision may be extended proximally to include the upper sternum; and the insertions of the sternocleidomastoid, scalenus anticus, and pectoralis minor muscles, when divided, provide excellent exposure of both the vessels and the brachial plexus. On the left, proximal subclavian arterial control is best obtained through an anterior thoractomy.

In the upper extremity, an important caveat for the primary surgeon is not to overlook brachial artery injuries associated with fractures and dislocations around the elbow. Sher[13] reported that arterial injuries occurred in 0.28 per cent of patients with fractures and dislocations of long bones, and these injuries may not be appreciated initially. It should be emphasized that, when the status of the distal pulses is in question, angiography is in order. Do not attribute diminished pulses to arterial spasm.

The lower extremity also poses interesting diagnostic and therapeutic challenges. The femoral artery is the most common site of arterial injury in the combined civilian and military statistics. Just as injuries around the elbow often have associated arterial trauma, so do fractures and dislocations about the knee. Indeed, many authors recommend angiography in all patients with this type of clinical presentation. The price often paid for an undiagnosed popliteal injury is thrombosis and subsequent amputation.

The amputation rate following popliteal artery injuries was approximately 30 per cent in both the Korean and Vietnam Wars. Civilian series have reported rates as high as 44 per cent, and only Perry et al[14] reported an amputation rate of less than 10 per cent. Rich et al[15] reviewed 125 popliteal artery injuries which led to amputation and drew the conclusion that prolonged ischemia and technical problems were responsible for the poor results. They listed several important points which might help to lower the amputation rate, including 1) the need for early diagnosis, 2) the importance of distal Fogarty catheter thrombectomy and heparinization, and 3) the necessity of repairing concomitant venous injuries and for immediate fasciotomy in selected cases.

In addition, the appropriate use of a fasciotomy may well mean the difference between success and failure in extremity vascular injuries. Following revascularization of an ischemic limb, the edema may be extensive and produce high compartmental pressure followed by arterial, venous, and neurological compromise. The indications for fasciotomy

in these patients are: 1) prolonged ischemia, 2) concomitant arterial and venous injuries, and 3) massive soft tissue swelling present at the time of surgery. The fasciotomy is best done at the time of the initial repair; however, the indications may not be appreciated until the postoperative period, at which time it should be carried out promptly. The technique of fasciotomy in the lower extremity includes opening both the anterior and posterior compartments with or without extensive skin incisions. It is felt by many that concurrent skin incisions provide the best decompression and should be used in each case.

In contrast to the more peripheral vascular injuries, those in the abdomen usually present minimal diagnostic challenges, since most penetrating wounds of the abdomen are surgically explored. Arterial injuries concomitant with blunt abdominal trauma are also readily recognized in most cases. On the other hand, intra-abdominal vascular injuries can be the most difficult from a therapeutic standpoint. A prime example would be an iliac artery injury associated with significant fecal contamination. In this situation, one would want to avoid any type of intra-abdominal bypass graft and probably use an extra-anatomical bypass to revascularize the lower extremity, provided the arterial injury could not be repaired by simple closure or an end-to-end anastomosis. In contrast, a splenic artery injury might best be managed by ligation and splenectomy, or a celiac artery injury by simple ligation. Renal arteries can be repaired by direct suture; end-to-end anastomosis; vein grafting; or, in some cases, transplantation to the pelvis with anastamoses to the hypogastric artery and iliac vein.

Summary

Obviously, these pages are only a summary of many words which could describe the diagnosis and management of arterial trauma. Many technical points were not included, and the problem of arterial injections was not discussed. However, the reader is referred to texts by Rich and Spencer[16] and by Rutherford[17] for more extensive information. The purpose was not to be specific in all situations, but to emphasize the importance of early recognition, efficient evaluation, and prompt therapy, always keeping in mind the classical rules of surgery regarding debridement of devitalized tissue and precise surgical technique.

References

[1]DeBakey ME, Simeone FA: Battle injuries of arteries in World War II: An analysis of 2,471 cases. Ann Surg 123:534-579, Apr 46.

[2]Hughes CW: Acute vascular trauma in Korean War casualties: An analysis of 180 cases. Surg Gynecol Obstet 99:91-100, Jul 54.

[3]Hughes CW: Arterial repair during the Korean War. Ann Surg 147:555-561, Apr 58.

[4]Rich NM, Manion WC, Hughes CW: Surgical and pathological evaluation of vascular injuries in Vietnam. J Trauma 9:279-291, Apr 69.

[5]Rich NM, Baugh JH, Hughes CW: Acute arterial injuries in Vietnam: 1,000 cases. J Trauma 10:359-369, May 70.

[6]Moss CM, Veith FJ, Jason R, et al: Screening isotope angiography in arterial trauma. Surgery 86:881-889, Dec 79.

[7]Snyder WH, Thal ER, Bridges RA, et al: The validity of normal arteriography in penetrating trauma. Arch Surg 113:424-426, Apr 78.

[8]Lavenson GS, Rich NM, Baugh JH: Value of the ultrasonic flow detector in the management of peripheral vascular disease. AM J Surg 120:522, 26 Oct 70.

[9]Rich NM, Hughes CW, Baugh JH: Management of venous injuries. Ann Surg 171:724-730, May 70.

[10]Brisbin RL, Geib PO, Eiseman B: Secondary disruption of vascular repair following war wounds. Arch Surg 99:787-791, Dec 69.

[11]Cohen CA, Brief D, Mathewson C: Carotid artery injuries: An analysis of eighty-five cases. Amer J Surg 120:210-214, Aug 70.

[12]Liekweg WG, Greenfield L: Management of penetrating carotid arterial injury. Ann Surg 188:587-592, Nov 78.

[13]Sher MH: Principles in the management of arterial injuries associated with fracture/dislocation. Ann Surg 182:630-634, Nov 75.

[14]Perry MO, Thal ER, Shires GT: Management of arterial injuries. Ann Surg 173:403-408, Mar 71.

[15]Rich NM, Baugh JH, Hughes CW: Popliteal artery injuries in Vietnam. Amer J Surg 118:531-534, Oct 69.

[16]Rich NM, Spencer FC: Vascular Trauma. Philadelphia, WB Saunders, 1978.

[17]Rutherford RB: Vascular Surgery. Philadelphia, WB Saunders, 1977.

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VII. Evaluation and Treatment of the Injured Hand

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Injuries to the upper extremity are rarely life-threatening. Yet the disability from the residual deformity profoundly alters life. Time does not permit us to discuss in great detail subjects about which volumes have been written. I would suggest to each of you, that, if your hand were injured only in a minor way, there would be a great change in your day-to-day activities and perhaps an inability to earn a living.

Because the disability is not life-threatening, the care of the injured hand is often relegated to the least experienced person or dismissed as unimportant. Certainly, this is a circumstance in which the initial treatment can vastly alter the final result. Neglect of the injury may cause irreparable harm, and overtreatment of an injured hand by somebody not experienced in hand surgery may produce a situation that cannot be rectified at a later date.

The first order of importance is to obtain a history and find out the method of injury and the location of the injury. The time that the injury occurred may dictate the choice of treatment. The occupation of the patient, and whether the dominant hand is involved, may also help the treating physician make critical decisions.

From the physical examination the attending physician must ascertain which tissues are involved; whether the skin coverage is lacking, or whether or not there is vascular impairment to the hand; whether the bony architecture has been interfered with — either in an open or a closed manner; and whether or not tendons, muscles or nerves have been damaged or severed.

There are priorities that must be kept in mind when treating hand cases after an accurate inventory of the damage has been obtained by history and physical examination. Blood supply must be re-established if it has been interfered with, skeletal stability should be obtained, and skin coverage to the hand achieved.

A patient with a hand injury should *not* be allowed to sit in an accident room with his hand soaking in a basin of soapy water. Following prolonged soaking, not only is the hand not cleaner, but bacteria may be introduced into a deeper plane. Usually the skin presents with a "dishpan hand" appearance, but is still dirty. If possible, the hand should be cleansed mechanically and covered with a sterile or certainly a clean dressing, through which x-ray studies can be obtained. Most bleeding can be controlled with pressure and elevation, and tourniquets or "blind" clamping of vessels should be avoided.

If skin and soft tissue replacement is needed, there are two major choices that must be made. One is the use of free skin grafts, and the other is the use of flaps. Flaps can be obtained locally, from adjacent areas, or from within the hand, such as from an adjoining finger. If the loss is greater, skin flaps from a distance may need to be employed.

Fractures of bones may be reduced by closed reduction; however, in many circumstances open reduction and stabilization is necessary. Joint injury must be considered, as well as ligament destruction, and dealt with.

While nerve injury is of utmost importance, immediate repair of nerves is not. Certainly, if the wound and patient's stability permit, an early repair would be advantageous; however, in an untidy wound or in a patient who has just eaten and requires a general anesthesia, the patient would be better served by closure of the wound and repair of the nerve at a later time.

Tendon injuries, although common, are often missed, especially on the extensor surface of the hand. Because of the thin covering over the extensor tendons, any patient with a wound of the dorsal aspect of the finger or hand should be approached with the possibility in mind that an extensor tendon is damaged. In clean wounds early repair of these tendons will give a far better result than repair at a later date.

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Flexor tendon injuries are complex because of the close association of two flexor tendons in each of the long fingers as they travel down a fibro-osseous canal in the finger. With recent advances in tendon surgery, more primary repairs are being performed in "no-man's land." These are usually done with dynamic splinting to permit guarded movement of the finger in a controlled range, while healing takes place. Injuries to the profundus tendon, distal to the insertion of the sublimis tendon, are often repaired primarily and, if farther distal, are treated by tendon advancement. Likewise, tendon injuries in the palm or wrist may often be repaired immediately with good results. When multiple structures are interrupted, as in a transverse wound of the volar wrist, rarely is it of advantage to repair all of the divided structures. Selectivity must be used to repair the profundus tendons, the ulnar and median nerve, and the flexor pollicis longus tendons. Depending on the nature of the wound, the sublimis tendons and the wrist flexors may often be left unrepaired with a good final result.

Nerve repairs are currently best performed under magnification, using fine mono-filament sutures. The use of an operating microscope or magnifying lenses has vastly improved the ultimate result of nerve repairs. There is still no agreement today whether the classic epineural repair or the more involved perineural fascicular repair yields a better result.

Amputation often is the treatment of choice in certain injuries to fingers. When amputation is required, a well-padded, soft amputation stump without the presence of painful neuromas is the object. The patient often will function better with an amputation that is slightly shorter, but not painful, and this should divert the treatment away from "preserving length at all costs."

The microvascular repair of certain injuries has advantages, and the re-implantation of fingers should be considered. This treatment is still in its infancy. Often the fingers that are re-implanted survive, but are insensate and immovable and may prove to be useless.

Proper splinting of an injured hand with elevation is of great importance in any hand injury. It will often insure a pain-free patient with absence of edema of the hand.

In summary, no matter how trivial a wound of a hand may seem, it is an economic disaster to its owner if it prevents his or her immediate return to work or carrying on in normal day-to-day activities. While many injured hands often result in decreased function when completely healed, the prime responsibility of the surgeon treating patients with hand injuries is to achieve as much function of the hand as can be obtained and, secondarily, to provide cosmetically as normal appearing a hand as can be obtained. In this way the patient can return to a useful and gainful life.

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VIII. The Evaluation and Immediate Care of the Patient with Spinal Trauma

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There are approximately 7,000 — 10,000 new spinal cord injuries per year.[16] Although automobile accidents are a major cause of these injuries, other activities contribute on a seasonal and regional basis. For instance, in the northeast skiing and snowmobiling during the winter and diving during the summer are frequent causes of spinal trauma.

Care of these injuries should begin at the scene of the accident. Transportation to the hospital and emergency room evaluation with care often affect the outcome. In as many as one half of the cases with a partial lesion, increased damage may result during the initial phases of treatment.[6] This discussion is limited to evaluation and immediate care of spinal trauma in the emergency room.

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All patients involved in major trauma are suspect of having spinal injury. The unconscious patient should be considered to have major spinal trauma until proven otherwise. The conscious patient can provide a history which may point to spinal trauma such as neck or back pain or the inability to move an extremity.

In all cases a brief but detailed history should be obtained from the paramedic who brings the patient to the accident room. Important is the type of accident, the position of the patient at the scene, external wounds, the paramedic's evaluations of motor or sensory function, and also how he secured and transported the patient. This information may aid in reconstructing the mechanism of injury and provide an assessment of the immediate neurological post injury status and bony or ligamentous stability of the lesion.

Once spinal trauma is recognized, the patient should be properly splinted if this was not done at the scene of the accident. He should be splinted from neck to buttocks because more than one area of the spine may be involved. This should be done with sand-bags for the neck and a spinal board for the thoracic and lumbar spine. Movement of the patient onto the board is done with a log roll motion, multiple person lifts (3-6), and longitudinal neck traction by hand. A cervical collar should not be used since it creates a false sense of security without providing stability. It may also obscure an expanding retropharyngeal hematoma or subcutaneous emphysema of the neck.

After the patient is splinted and completely undressed, a general physical examination should be performed. Next, a cursory neurological examination is in order to establish gross parameters which can be monitored while the patient undergoes initial resuscitation and further evaluation. This includes the ability to flex and extend the toes, ankles, fingers, wrists, and other parts upon command, and gross sensory levels. Specific lesion levels can be established later during a secondary evaluation.

At this point further evaluation is necessary to rule out other potential problems which these patients may have. Some of these problems require immediate treatment.

Hypotension may result from two sources. One is hemorrhagic shock, which causes a rapid and unsteady pulse. The other is neurogenic shock. This occurs in quadriplegics and high paraplegics as a result of the sympathectomy effect from the spinal lesion. This form of hypotension is accompanied by a normal pulse or bradycardia. It results from peripheral pooling of fluids which leads to poor tissue perfusion. Fluid resuscitation alone will not suffice. It may, in fact, result in fluid overload. Atropine to block the sympathetic effect along with reverse Trendelenberg position often aids in decreasing hypotension and increasing effective tissue perfusion. Constant monitoring of vital signs and central venous pressure is extremely important in assessing the effects of fluids and drugs in combating this problem. Shock during this period in this group of patients is a major cause of mortality.

Respiratory distress may result from the neurological lesion, airway obstruction, direct chest trauma, or any combination of these problems. Neurological involvement occurs especially with spinal trauma above the C-4 level since this involves the phrenic nerve and diaphragm. Lower lesions affect the use of intercostal muscles and accessory respiratory muscles while diaphragmatic breathing remains intact. Airway obstruction secondary to direct trauma, swelling, or aspiration is very common. Finally, major trauma may result in such problems as a flail chest, pneumothorax, and hemopneumothorax. Diaphragmatic breathing secondary to cord injury superimposed upon chest trauma is ominous.

Blood gases should be obtained to determine the pO_2 and pCO_2. Respiratory function can be rapidly assessed by asking the conscious patient to sigh, cough, or forcibly exhale. If he cannot, he probably has a vital capacity of less than 25 per cent predicted normal and respiratory assistance should be provided. If intubation is required, an immediate portable lateral x-ray film of the neck should be obtained to rule out any gross abnormalities. Even if no gross abnormalities are seen, if a neck injury is still suspected, intubation should be attempted through the nasotracheal route with minimal neck movement. A tracheostomy should be avoided if possible, because it may compromise an anticipated anterior surgical approach to the neck and is a potential source of sepsis. Respiratory complications during this period represent the second major cause of mortality in this group of patients.

Assessment of intra-abdominal pathology can be extremely difficult. Spinal fractures with or without neurological damage may produce an adynamic ileus with secondary abdominal distention. Lesions which cause quadriplegia or paraplegia may also cause a loss of abdominal pain, lack of guarding, and a disarmingly soft abdomen, which under other circumstances would be painful and rigid. On the other hand there have been case reports of incomplete cord transection that caused abdominal

rigidity which could be confused with intra-abdominal disease.[1] Finally, the abdomen may reflect changes from lesions other than the spinal fracture or intra-abdominal trauma. An example is a retroperitoneal hemorrhage secondary to a pelvic fracture.

Evaluation of these problems should include a careful physical examination. In certain lesions, such as the Chance fracture, there may be telltale skin bruises across the abdomen from the seat belt.[5,18] Abdominal taps, abdominal x-ray films, arteriograms, scans, and ultrasound are also useful in the final diagnosis of an intra-abdominal lesion.

Long bone fractures and joint dislocations may initially go unrecognized. Remember that pain may be absent, leaving deformity and crepitus with motion as the only clues. It may be difficult to evaluate local neurological damage secondary to the fracture or dislocation because of a cord or root lesion. However, it is important to determine if a peripheral lesion is present, since it may result in a useless limb, even if the central lesion resolves. Peripheral vascular lesions are difficult to evaluate for the same reasons. Lack of pulses in a painless extremity may be the only indication of impending vascular disaster.

Special care must be taken when immobilizing extremity injuries in the patient with spinal trauma. Since the watch dog of pain may be absent, air splints which can cause circulatory embarrassment should not be used. Proper joint positioning is important and meticulous skin care is urged because undue pressure may cause extensive skin breakdown.

Finally, the evaluation of head trauma may be quite difficult. Quadriplegia may mask a hemiplegia which can occur secondary to head trauma. A Horner's syndrome from a cervical cord injury may distort pupillary dilation secondary to intracranial pressure.

The preceding paragraphs have dealt with the initial evaluation of this group of patients. It provides information leading to a general diagnosis of injuries, order of priorities with regard to these various injuries, and the necessary information to institute early resuscitation. It also provides parameters with which to monitor the patient while undergoing secondary evaluations. The secondary evaluations are designed to provide more specific information about each area of injury. The remainder of this discussion will deal only with the evaluation of spinal trauma.

The first step in the secondary evaluation of this problem is to obtain a detailed neurological history. This should include a review of the accident with regard to mechanism of injury, the presence of any neurological deficits (incomplete or complete), the onset of neurological problems, ie, immediate or gradual, the deterioration of neurological status since the time of the accident, and any previous history of cervical, thoracic, or lumbar spine disease. It should also include questions regarding areas of pain near the spine, such as suboccipital pain, neck stiffness, or pain in the mid back and at the thoracolumbar junction.

After this detailed history is taken, a thorough physical examination is performed. One should look for skin lesions which may help delineate the mechanism of injury. Telltale marks may be present on the top of the head, face, shoulders, scapula, abdomen, or back. Palpation of the spine may reveal specific areas of pain and widening of the interspinous distance. Observation of arm position may provide information as to the level of a cervical spine injury.[11]

A detailed neurological examination should be carried out. This requires extensive knowledge of spinal cord anatomy including root levels, levels of cord segments as related to bony anatomy, and the position of various tracts within the cord.[7,8] Key factors include voluntary motion, sacral spearing, presence of various reflexes, and penile erection.[8,19] If the lesion is incomplete, careful grading of motor function should be carried out and recorded. A similar evaluation of areas of sensation should be made.

Once the history and physical examination have been completed a tentative clinical diagnosis can be made. This should include a determination of the level of the lesion, whether it was complete or incomplete, and whether the deficit was instantaneous following injury or had shown progressive deterioration or improvement. Regarding the level of the lesion, it is important in the case of the spine to correlate the clinical level with the roentgenographic level. This will help to determine if the root which comes from the segment above the lesion and exits at the level of the lesion is involved. This can usually be considered a peripheral lesion and should be watched closely for return of function. Incomplete lesions in the cervical region may present as a variety of syndromes, including the anterior cord syndrome, central cord syndrome, Brown-Sequard syndrome, and posterior cord syndrome. Complete lesions in the area of the thoracolumbar junction (below the level of T-10) can be a combination of cord and root lesion.[19] Therefore the prognosis is guarded, as some return may occur secondary to recovery at the root lesions.

The final step in the secondary evaluation of spinal trauma is the roentgenographic examination. The patient must be handled carefully while taking these films. Several persons should turn the patient as previously described. If available, a Stryker frame may be helpful in transporting and positioning the patient. Films of the entire spine should be taken if there are abnormal clinical findings, since lesions may be present at more than one level. Lateral views of the cervical spine must include C-7. Open mouth, anterior, and oblique films are also necessary to evaluate the cervical spine. The method described by Beatson to obtain oblique views of the cervical spine is safe and easy.[2] Flexion and extension films of the cervical spine are risky even with a physician present. In general, they should not be requested except when a patient with normal films and no neurological abnormalities complains of neck pain. When there are abnormal x-ray findings or neurological abnormalities, there is no need for flexion and extension neck films during the immediate post-injury period.

Tomography is useful if there is difficulty interpreting regular films. However, this is being superseded in many centers by the computerized tomography (CT) scan.

Myelography during this period remains controversial. Many feel that it is not indicated as a routine test in all spinal injuries, but only when there are specific indications. These include a progressive neurological deficit, neurological damage without identifiable skeletal damage on routine films, and lack of correlation between the level of neurological damage and the level of skeletal damage on routine films.[12,19]

Upon completion of the secondary evaluation, acute management of the spinal injury begins. A plan of treatment is evolved by integrating the various results of the evaluation. The clinical evaluation provides a neurological diagnosis, while x-ray studies provide a morphological diagnosis such as fracture, dislocation, fracture-dislocation, and subluxation. The x-ray films may also provide more specific morphological information, eg hangman's fracture, slice fracture, burst fracture, bilateral or unilateral facet dislocation, or others.

Using all of this information, a decision based on previously described criteria is made as to whether the lesion is stable or unstable and whether reduction is necessary.[8,13,15,17,20] This decision determines whether to use skeletal traction or an appropriate orthosis for acute immobilization of cervical spine injuries.[10,20] A Stryker or Foster frame can be used for the acute immobilization of thoracolumbar spinal injuries. A discussion of the decision for surgical intervention is not included since it would be beyond the scope of immediate post-injury evaluation and care of such patients.

One should be aware of the early secondary effects of these injuries. Adynamic ileus is very common and should be treated with a nasogastric tube. Gastric ulceration and hemorrhage can occur secondary to stress as early as the second day after injury. An indwelling Foley bladder catheter should be used to monitor urine output. If hypotension is present secondary to a sympathectomy effect, diuresis usually begins about 48 hours after injury. Once this occurs, the catheter should be removed and intermittent catheterization should be started.[4,16] Early skin care is necessary to prevent sacral and peripheral decubiti. Proper nursing usually requires a turning frame such as a Stryker or Foster frame. The Stryker circo-electric bed, unless specifically outfitted for spinal trauma, is contraindicated. The use of steroids remains controversial. They are often given during the acute post-injury period in an attempt to improve the neurological status. However, it has been shown that the spinal cord plays a role in the feedback mechanism for the regulation of endogenous steroids.[9] Therefore, during spinal shock supplementation of endogenous steroids is now believed to be necessary.

References

[1]Abbott KH: Abdominal Rigidity: A symptom of concussion of the spinal cord. Arch Neurol & Psychiat 57:220-227, Feb 47.

[2]Beatson TR: Fractures and dislocations of the cervical spine. J Bone Joint Surg 45B:21-35, Feb 63.

[3]Bosch A, Stauffer ES, Nickel VL: Incomplete traumatic quadriplegia. A ten year review. JAMA 216:473-478, 19 Apr 71.

[4]Comarr AE: Early management of the spinal cord injury patient. Jaipur, India, Association of Surgeons of India, Orthopaedic Section, 1963.

[5]Grantham SA, Malberg MI, Smith DM: Thoracolumbar Spine flexiondistraction injury. Spine 1:172-176, Sep 76.

[6]Green B: Personal communication.

[7]Holdsworth FW: Fractures, dislocations, and fracture-dislocations of the spine. J Bone Joint Surg 45B:6-20, Feb 63.

[8]Holdsworth FW: Fractures, dislocations, and fracture-dislocations of the spine. J Bone Joint Surg 52A:1534-1551, Dec 70.

[9]Hume DM: Endocrine and metabolic responses to injury, in Schwartz SI (ed): Principles of Surgery. New York, McGraw-Hill, 1969, pp 3-24.

[10]Johnson RM, Hart DL, Simmons EF, et al: Cervical orthoses: A study comparing their effectiveness in restricting cervical motions in normal subjects. J Bone Joint Surg 59-A:332-339, Apr 77.

[11]Kahn EA: On Spinal cord injuries. J Bone Joint Surg 41A:6-11, Jan 59.

[12]Kaufer H, Hayes JT: Lumbar fracture-dislocations: A study of twenty-one cases. J Bone Joint Surg 48-A:712-730, June 66.

[13]Kelly RP, Whitesides TE Jr: Treatment of lumbodorsal fracture-dislocations. Ann Surg 167:705-717, May 68.

[14]Marar BC: The pattern of neurological damage as an aid to the diagnosis of the mechanism in cervical spine injuries. J Bone Joint Surg 56A: 1648-1654, Dec 74.

[15]Moe JH, Winter RB, Bradford DS, Lonstein JE: Scoliosis and Other Spinal Deformities. Philadelphia, WB Saunders, 1978.

[16]Pitts FW, Stauffer ES: Spinal injuries in the multiple injured patient. Ortho Clinics of No Am 1:137-149, Jul 70.

[17]Roberts JB, Curtiss PH: Stability of the thoracic and lumbar spine in traumatic paraplegia following fracture or fracture-dislocation. J Bone and Joint Surg 52A:1115-1130, Sep 70.
[18]Smith WS, Kaufer H: Patterns and mechanisms of lumbar injuries associated with lap seat belts. J Bone Joint Surg 51A:239-254, Mar 69.
[19]Stauffer ES, Kaufer H: Fractures and dislocations of the spine, in Rockwood CA, Green DP (eds): Fractures. Philadelphia, JP Lippincott, 1975, pp 817-904.
[20]White AA, Southwick WO, Panjabi MM: Clinical instability in the lower cervical spine: A review of past and current concepts. Spine 1:15-27, Mar 76.

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IX. Acute Care of Facial Injuries and Reconstructive Opportunities

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I. Early Management of the Acutely Injured

The primary problem associated with maxillofacial injuries is airway obstruction, early and late. Initial triage must first consist of inspection of the oronasoprarynx for foreign bodies (teeth and dentures), hemorrhagic plugs, and other particulate matter.

Aspiration is a major immediate complication and can be minimized by placing the patient in the right lateral position with the head and jaw gently extended. Overextension of the head and neck must be avoided until cervical injuries can be ruled out. Endotracheal intubation may be required if the patient is unable to control the airway. Injury to the larynx may necessitate tracheostomy. Bilateral comminuted mandibular fractures can result in uncontrollable glossoptosis with associated airway obstruction.

Persistent hemorrhage usually occurs with severely displaced facial bony segments. Middle facial injuries often require placement of anterior or posterior tamponading nasal packs, or both. Mandibular fragments, if displaced, may cause profuse hemorrhage which can be controlled by manually reducing the fractures.

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Once the airway obstruction and hemorrhage have been identified and controlled, the primary problem then becomes the determination of concomitant injuries prior to obtaining radiographs. Patients should be stabilized by intravenous lines, nasogastric tubes, urinary catheters, central venous pressure (CVP) lines, and other means to prevent shock and its sequelae.

II. Diagnosis of Facial Fractures

A. Types. Facial fractures are classified as follows: 1. frontonasoethmoidal; 2. malar – orbital floor; 3. maxillary – LeFort I, II, III; 4. mandibular; 5. nasal; and 6. combinations of 1 and 5.

All facial injuries must be considered as head injuries. Immediate repair of soft and bony tissue injuries can wait until the patient can be totally evaluated and stabilized.

B. Clinical evaluation. Frontonasoethmoidal fractures. These occur independently or in conjunction with naso-orbital fractures; fractures of the lower portion of the frontal bone and the supraorbital and glabella regions are relatively infrequent. Depression of the frontal bones is associated with late periorbital edema and ecchymosis. Diplopia may occur when the trochlear nerve and superior oblique muscle are involved. Ptosis may result due to damage of the levator palpebrae superioris muscle. Frontal sinus fractures can be reduced at a later date assuming that there are no associated head injuries. Cerebrospinal fluid rhinorrhea may be diagnosed by the presence of a glucose level of 30 mg per 100 ml of fluid.

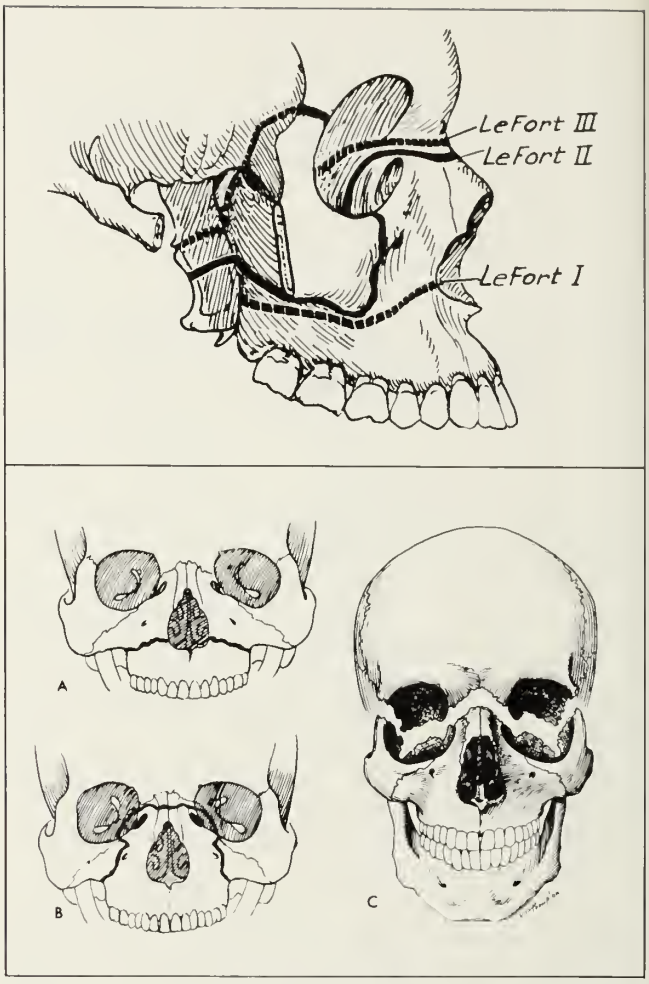
Malar — orbital fractures. Deformities and functional impairments are usually late complications which can be reduced by early diagnosis and treatment. Diagnosis is often obscured by severe cranial and facial injuries. For example, the unconscious patient cannot experience diplopia; orbital edema, hemorrhage, and ptosis can mask enophthalmos. Classic signs and symptoms are facial asymmetry, limitation of the extraocular movements, enophthalmos, diplopia, decreased visual acuity and blindness, optic nerve and central retinal artery ischemia, corneal abrasions, ruptures of the globe, vitreous hemorrhage, dislocated lens, rupture of the sclera, choroidal rupture, ruptures of the iris sphincter, retinal detachment, interruption of the continuity of the lacrimal apparatus, neuropathy along the distribution of the infraorbital nerve, and trismus secondary to impingement upon the coronoid process by a depressed zygomatic arch. Next to mandibular condylar fractures, minimally displaced frontozygomaticomaxillary complex and blow-out fractures are the most commonly missed facial fractures.

Nasal Fractures. Diagnosis is often obscured by edema and hematoma formation. Obstruction, subcutaneous emphysema, increased mobility, crepitation to palpation, and asymmetry are common findings.

LeFort I fractures (Figs. 1 and 2). This type of maxillary fracture occurs above the level of the apices of the teeth and often includes segments of the alveolar process. It is manifested clinically by malocclusion, ecchymosis, epistaxis, and swelling of the maxillary vestibule.

LeFort II fractures (Figs. 1 and 2). This type of maxillary fracture extends through the frontal process of the maxilla and then laterally through the lacrimal bones, floor of the orbit, zygomaticomaxillary suture, lateral wall of the maxilla, and pterygo-maxillary fissure. These symptoms are similar to those of LeFort I fractures with concomitant orbital/nasal edema, ecchymosis, neuropathy, and possible CSF rhinorrhea.

LeForte III fractures (Figs. 1 and 2). This type of maxillary fracture is classified as a craniofacial disjunction. These fractures extend across the zygomaticofrontal sutures, nasofrontal sutures, and orbital floors. The maxillary fractures may not be separated from the zygoma or the nasal structures. Symptoms are similar to those of the LeFort I and II fractures but also include: cerebrospinal fluid rhinorrhea/otorrhea, bilateral periorbital edema and ecchymosis, dish-faced appearance, and movement of the entire middle face including the bridge of the nose.



Figures 1 and 2. LeFort I, II and III Types of Maxillary Fracture.[6]

Mandibular fractures (Fig. 3). Fractures of the mandible involve the condylar head (intracapsular), condylar neck (extracapsular), coronoid process, ramus, body, symphysis, and alveolar process. Signs include: malocclusion, inferior alveolar neuropathy, preauricular edema, elevation of the floor of the mouth and tongue, trismus, glossoptosis, periorbital and vestibular edema, ecchymosis, and hemorrhage. The most commonly missed facial fractures are those involving the mandibular condyles. Children who present with chin lacerations should always have radiographs for occult fractures of the mandibular condyles. These injuries frequently result in latent malocclusion, Temporomandibular joint ankylosis, and interruption of mandibular growth and development.

C. Radiographic evaluation. Patients who have sustained facial injuries require a radiographic series including skull, facial bone and cervical spines.

If fractures of the orbit and LeFort III fractures are anticipated, orbital tomograms are helpful to

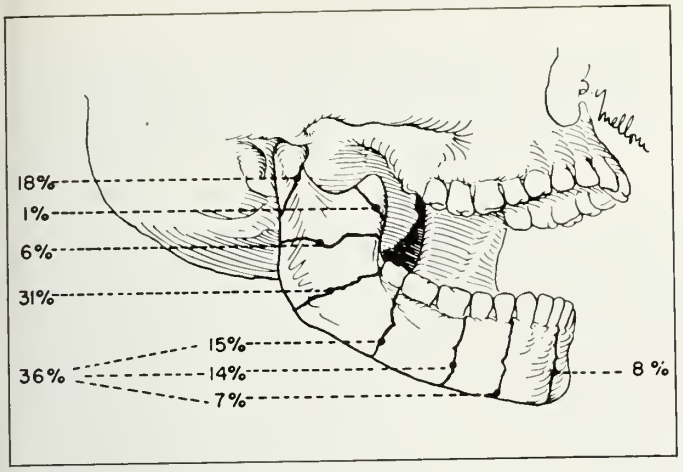


Figure 3. Mandibular Fractures.[6]

diagnose "blow-out" injuries. If mandibular condylar fractures are anticipated, temporomandibular joint views, and transorbital and transpharyngeal projections of the condyle may be of value.

III. Concomitant Injuries.

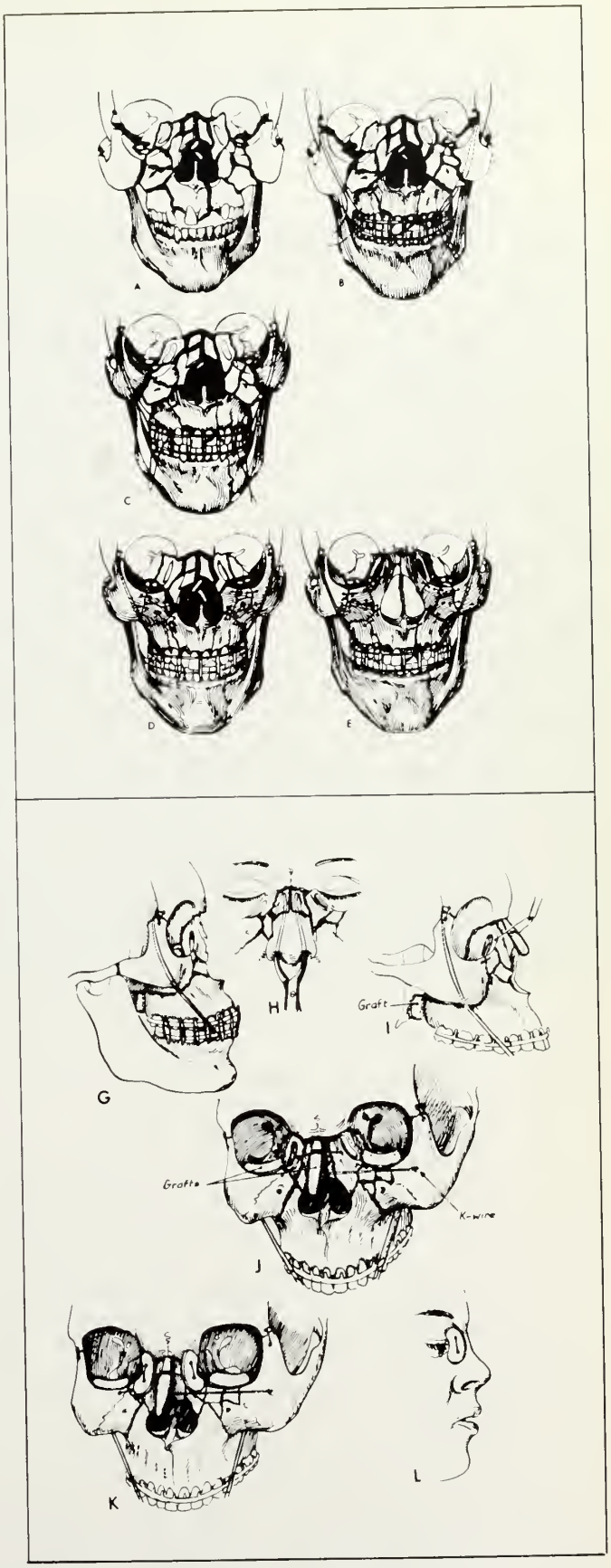
Personal experiences with early and late complications have included the following: skull fractures, epidural and subdural hematomas, cerebrospinal fluid (CSF) rhinorrhea and otorrhea, fractured odontoid process, phrenic nerve injury with diaphragmatic paralysis, palsies involving cranial nerves III, IV, V, VI, VII, unilateral and bilateral spontaneous pneumothorax, flail chest with cardiac tamponade, lacerations of the liver, spleen and mesenteric vessels, ruptured bladder, fat embolism, and extremity injuries.

These experiences indicate that primary care may need to be postponed at least 8 to 12 hours until all symptoms have been evaluated and stabilized. However, edema frequently distorts facial form complicating accurate wound repair and definitive treatment.

IV. Treatment of Facial Fractures

All soft tissue injuries should be temporarily debrided, hemorrhage controlled, and wound margins loosely approximated (Figs. 4, 5 and 6). Except in the removal of obviously devitalized portions of tissues, aggressive debridement has no place in the management of facial injuries. All tissues that may participate in a satisfactory repair should be retained if there is any possibility of residual vitality in these structures. The blood supply to the face makes extensive debridement unnecessary.

When considering multiple trauma priorities, it



Figures 4 and 5. Treatment of Facial Fractures.[6]

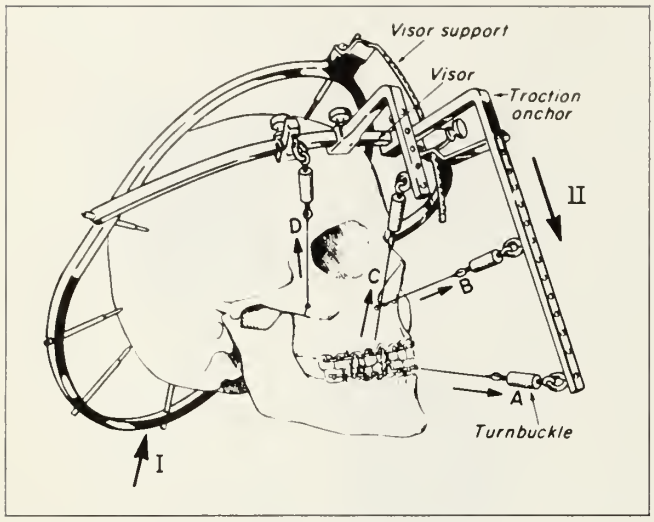


Figure 6. Treatment of Facial Fractures.[6]

is poor surgical judgement to repair all facial soft tissue wounds when concomitant underlying facial bone fractures are present. Lacerations are frequently approximal to facial bone fractures facilitating open reduction procedures, whereas repaired soft tissue wounds must often be disturbed at the time of bony reductions.

When fractures exist involving the middle face and mandible, it is prudent to reduce, fixate, and immobilize the mandibular fractures as the first stage of treatment. This establishes an occlusal and bony framework upon which to stabilize the middle face vertically, anteroposteriorly, and transversely. The dentition is the cornerstone to reconstruction except with isolated injuries of the zygoma, orbit, nasal, ethmoidal, and frontal bones. Multiple injuries such as LeFort fractures with comminuted bilateral mandibular fractures frequently require the use of extraskeletal cranial suspension utilizing headframes and biphasic pin appliances.

The craniodentofacial complex is an organ system requiring attention to detail and meticulous surgical techniques. Closed and open reductions can be employed depending upon the nature of the injury and the skill of the surgeon. All facial bone injuries from the infraorbital rims to the mandible can be approached by a trans-oral procedure in many instances. This obviates the necessity for skin incisions and further soft tissue scarring. Frontonasoethmoidal, orbital, and LeFort III fractures require the use of various open procedures.

V. Complications and Secondary Reconstruction

Complications may arise particularly in the multiple injury patient. The surgical specialties involved in the management of these patients include oral and maxillofacial surgeons, ophthalmologists, plastic surgeons and otolaryngologists. A multi-disciplinary team approach often includes a neurosurgeon and a general surgeon. A team approach optimizes treatment and minimizes morbidity and mortality. Complications include: infection, osteomyelitis, malunions, nonunions, facial asymmetries, scar contractions, avulsive bony and soft tissue defects, malocclusion, persistent diplopia, enophthalmos, blindness, canthal and lid deformities, extraocular muscle imbalance, 5th and 7th cranial nerve, neuropathies, temporomandibular joint dysfunction, sialoceles, and emotional disturbances.

Secondary reconstruction must be predicated upon the concept of restoration of function first and esthetic considerations second. Lack of soft and hard tissues frequently necessitates multiple bone grafts preceded by free and pedicle soft tissue grafts. Bone grafts will fail unless they are adequately designed, immobilized, and covered by soft tissue. Esthetic goals are often not realized. Moreover, the operative procedures require intense motivation and cooperation on the part of the patient.

Restoration of oral and maxillofacial function can be complicated by edentulous segments, alveolar bone deficiencies, discontinuity defects, antral defects, and neuromyopathies.

Summary

Careful planning, attention to detail, adequate reduction and immobilization, appropriate handling of soft tissues, surgical expertise, absence of infection, appropriate nutrition and meticulous postoperative wound care will all minimize the need for secondary reconstructive procedures in many cases. The care of these patients frequently requires a well-staged multi-disciplinary team approach.

References

[1]Shires GT (ed): Care of the Trauma Patient. New York, McGraw-Hill, 1966.
[2]Irby WB: Facial Trauma and Concomitant Problems: Evaluation and Treatment. St. Louis, CV Mosby, 1974.
[3]Rowe NL, Killey HC: Fractures of the Facial Skeleton. London, E & S Livingstone, 1968.
[4]Epker BN: Open Surgical Management of Naso-Orbital-Ethmoid Facial Fractures. Copenhagen, Munksgaard, 1973, 323-329.
[5]Mathog RH, Rosenberg Z: Complications in the treatment of facial fractures. Otolaryngol Clin North Am 9:533-552, June 76.
[6]Converse JM (ed): Reconstructive and Plastic Surgery: Facial Injuries, Orbit, Nose, Cranium, ed 2. Philadelphia, WB Saunders, 1977.

221 Angell Street
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August 1980
Volume 63, Number 8

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NEWSLETTER

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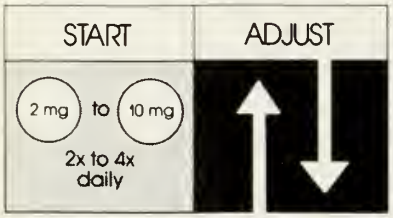
Monitoring patient response to Valium® (diazepam/Roche)

Assessing initial response to therapy

During the first follow-up visit after initiating therapy, both physician and patient should determine if Valium (diazepam/Roche) is having the desired effect. Most patients will promptly report a feeling of relaxation and relief of anxiety-linked symptoms such as insomnia, headaches, palpitations and hyperventilation. You will probably observe that the patient is calmer and more relaxed. If, however, patient response does not measure up to expectations, a reevaluation of the patient's profile with modification of the dosage regimen should be considered.

Making dosage adjustments



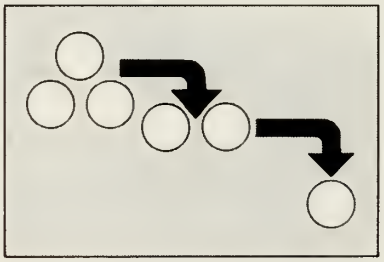
With any psychoactive medication it is good medical practice to initiate therapy at base dosage levels and titrate to the patient's needs. With Valium, experience has shown that 5 mg t.i.d. is usually sufficient although some patients with severe or persistent anxiety may require higher dosages initially. In geriatric or debilitated patients, the recommended dosage is 2 to 2½ mg once or twice daily. When anxiety fluctuates, as is common with most patients, the dosage may be adjusted as needed during the course of therapy; three strengths in scored tablets give you unmatched flexibility and simplicity in individualizing dosage.

Evaluating progress toward therapeutic goals

SET GOALS						
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	31		

At the beginning of therapy it is now common practice for both physician and patient to establish treatment goals and to estimate the amount of time needed to achieve them. Then the patient knows what to expect and when to expect it. Some physicians find that compiling a checklist of presenting symptoms and complaints is useful for assessing the patient's response from visit to visit. In this way, progress toward attainment of the therapeutic goal is reviewed at regular intervals. As patients feel their symptoms abate and begin to develop insight into the sources of their anxiety and psychic tension, the checklist can be expected to dwindle.

Discontinuing pharmacologic intervention



When you decide to discontinue therapy, tapering dosage is good medical practice. Although rarely necessary after short-term treatment with Valium, gradual dosage reduction is advisable for patients who have been on extended therapy. This gradual discontinuance should preclude either recurrence of pretreatment symptoms or development of untoward side effects. Symptoms of withdrawal have almost always been associated with abrupt discontinuance of therapy at higher dosages taken continuously over long periods of time.

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The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma, may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Dosage: Individualize for maximum beneficial effect. *Adults*: Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients*: 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children*: 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

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Single Copies $1.00-Subscriptions $10.00 per year (Members of the Rhode Island Medical Society, $5.00 annually), Second Class postage at Providence, Rhode Island
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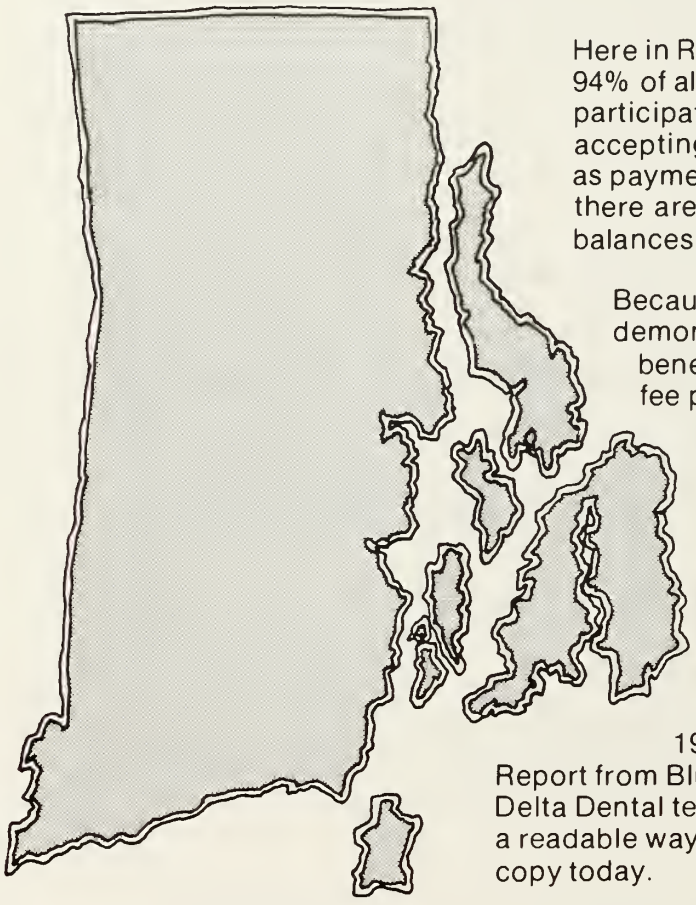

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COVER

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Rhode Island Medical Society

August 1980

Newsletter

Peter L. Mathieu, Jr., MD, Editor
Karen Challberg, Associate Editor

Exercise Prescription

David A. Herrara, MD

I believe implicitly the message that I have heard many times: "Do not overestimate the inevitability of deterioration from aging and do not underestimate the ability of the elderly body to respond to reasonable demands."

The physiological, psychological, socioeconomic, and epidemiological effects of exercise are gradually being defined by many investigators around the world.

Exercise can postpone decline in aerobic capacity by up to 20 years as pointed out by Doctor Per-Olaf Astrand of Stockholm, Sweden. In sedentary persons the maximal oxygen uptake begins to decline at age 20. In vigorous exercisers the maximal oxygen uptake starts to decline after age 40. "Exercise keeps the lungs younger," as stated by Doctor Richard Riley of John Hopkins University. The ventilation capacity of the lungs decreases with age, but improves with exercise training.

Exercise increases circulatory efficiency. Doctor Bengt Saltin of Copenhagen and other investigators maintain that exercise compensates for declining central cardiovascular function by increasing efficiency at the capillary level. The increased efficiency is manifested by a widened femoral arterial-venous oxygen difference. In other words, adequate muscular training will make the tissues extract the oxygen from the blood more efficiently. Exercise training increases the cardiac output, stroke volume, the coronary artery vessel diameter, collateral blood flow, and capillary/fiber ratio. Exercise decreases myocardial oxygen consumption and heart rate.

Exercise reduces sympathetic nervous system irritability. Doctor L. Howard Hartley of Harvard University has demonstrated that levels of the catecholamine norepinephrine are lower in persons who are exercise-conditioned. Levels of growth hormone and insulin are higher.

Exercise restores youthful muscle/fat ratio, and in so doing may restore more youthful metabolic rates and reverse those changes in body composition that occur with aging. Doctor Jana Pariskova of Prague, Czechoslovakia and Doctor Francisco Grande of Spain have done extensive research in the subject.

Exercise decreases triglyceride production, very low density lipoproteins, and chylomicron production in the intestines and increases high density lipoproteins and fibrinolysis. These effects will contribute to the prevention of atherosclerosis. Also, exercise may result in lower blood lactate levels and higher renal and splanchnic blood flow.

The exercise that appears to be most beneficial is dynamic isotonic exercise with low resistance, high rate, and high repetition, as compared with static isometric exercise, which can be hazardous to the health.

Jogging, running, swimming, biking, skiing, skating, hiking, soccer, tennis, and rowing are among the dynamic isotonic exercises that are popularly accepted.

For an exercise prescription I evaluate the different systems: cardio-vascular, osteo-arthro-muscular, respiratory, metabolic, neurological and psychological. A cardiovascular examination and exercise stress testing are essential. Then I recommend attention to biomechanics: proper stretching exercises, exercises to avoid muscle compartment imbalance and the overuse syndrome. Environmental factors also have bearing. Proper breathing techniques and breathing exercises are helpful. A balanced diet is important. There is no proof that any irrational special dietary trick or drugs are beneficial. Fluid and electrolyte replacement are important. Avoidance of boredom, proper sleep, rest, and relaxation are significant requisites.

I believe that Concentration, Humility, Attitude, Modesty, Perseverance, and Sacrifice are the attributes of CHAMPS.

I believe that exercise greatly enhances the quality of life.

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Medical Journalist Wins Fellowship

Bruce DeSilva, medical writer for the *Providence Journal,* is one of 24 winners of fellowships awarded by the National Endowment for the Humanities to study in special fields in furtherance of careers in journalism. His fellowship is for $18,000 for nine months beginning in September 1980 at the University of Michigan, where all of the university resources will be available to him in support of independent work. Bruce plans to use the time to concentrate on medical-legal-ethical issues affecting the future of recombinant DNA, treatment of retarded persons, and other concerns as they evolve while he is there. The University of Michigan's well-known Center for the Study of Retardation will be a prime resource to pursue his interest in legal problems of retarded persons. He will return to the *Providence Journal* in June 1981.

Media relationships are an absolute prerequisite for effective pursuit of the aims of the doctors in Rhode Island. Individual physicians, district and specialty societies, and the Rhode Island Medical Society as a focus, must work together to get our message to the fourth estate. At times this has been difficult. Perhaps by the efforts recently put forth to establish relationships with the media over the State Health Plan physicians' messages will be heard more clearly from now on. Mike D'Ambra and Ed Gaulin (Pawtucket); Don Jeffrey (Woonsocket); Barbara Lloyd (Newport); and Bruce DeSilva, Bob Chiappinelli, Karen Ellsworth, James Rhea, and Greg Roberts (Providence) are only a few who we know to be interested in our concerns. We must relate to these professionals and to the community to inform the people in a positive manner of the many things doctors are doing for them. ■

Peripatetics

Henry T. Randall, MD was recently Professor Pro Tem at the University of Texas Medical School Southwestern Division and delivered a lecture on "Nutrition in Critically Ill Patients".

At the recent meeting of the American Osler Society in Boston **Irving A. Beck, MD** delivered the Presidential Address titled "The Providential Visits of William Osler".

Albert S. Most, MD has been elected to a three-year term on the Board of Governors of the American College of Cardiology.

Georges Peter, MD has been appointed to a three-year term on the Committee on Infectious Diseases of the American Academy of Pediatrics.

The American College of Chest Physicians has elected **Guy A. Settipane, MD** Governor for Rhode Island for a three-year term ending in 1982.

Charles E. Millard, MD has been appointed to the five member ad hoc task force on aging of the American Academy of Family Physicians.

Member **Agostino Sammartino, MD** has been in the practice of medicine for 52 years.

Recently elected fellows of the American College of Physicians are **Robert J. Capone and Richard P. D'Amico, MDs.**

Newly elected officers of The Miriam Hospital Staff Association are **Philip A. Torgan, MD,** President; **Mehrdad Motamed, MD,** Vice President; **M. Howard Triedman, MD,** Treasurer; **Barry B. Schwartz, MD,** Secretary.

Medical Meetings

AUGUST 1980

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SEPTEMBER 1980

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August

5 Society Management Committee (RIMS); meeting; 7:00 pm
6 Maternal Health Committee (RIMS); meeting
7 Insurance Committee (RIMS); meeting, 7:00 pm
8 RI Chapter, American Academy of Pediatrics; regular meeting; RIMS Building; 7:30 pm
14 Statewide Health Coordinating Council; regular meeting; 5:00 pm
18 Rhode Island Medical Society Council; regular meeting; 6:00 pm
25 Educational and Scientific Board (CME) (RIMS); 7:30 pm

September

8 Staff Physicians Association of Rhode Island; regular meeting; Roger Williams General Hospital
17 Annual Golf Tournament and Dinner (Providence Medical Association)
18 Pawtucket Medical Association; meeting; Checker Club; 6:30 pm; (speaker: Peter L. Mathieu, Jr., MD)
22 Irish-American Pediatric Society; Cork, Ireland
24 Rhode Island Medical Society House of Delegates; regular meeting; 2:00 pm

October

2 Blue Cross Board; regular meeting; 5:30 pm
6 Rhode Island Medical Society Council; regular meeting; 6:00 pm
8 New England Pediatric Society; fall meeting
14 Providence Surgical Society; regular meeting
18-19 New England Society of Allergy; fall meeting; Sheraton-Islander Inn, Newport
20 Blue Shield Board; regular meeting; 6:00 pm

Interview of the Month:

J. Douglas Nisbet, MD

Doctor Nisbet is one of the long-time quiet supporters of Rhode Island Medical Society affairs, contributing wise council, inspiration, and his time, when needed. He has been a member of the Council, the House of Delegates, was a recent President's appointee to the Nominating Committee, among other activities. By him the Kent County Medical Society has been well represented.

The Doctor is of the first generation of physicians in his family. His own father was a toolmaker, of whom two sons, J. Douglas and his brother, became doctors, and it appears that this was just the beginning of a tradition. Of Doctor Nisbet's five children, three, including his youngest, Deborah, are looking forward to a medical or related career. His oldest son Douglas has completed his first year of studies at New York Medical School; Matthew, now 17 years old and a student at Moses Brown School, wants to be an orthodontist; and Deborah, aged 12, thinks she will be an obstetrician someday. Not that the Doctor will be any less pleased when Steven ("Rusty"), now in his third year of a pre-law program at Trinity College, and Mark, in his third year of an engineering course at the University of Rhode Island, accomplish their respective goals.

The Doctor met his wife, who was a practicing nurse and now is invaluable to him in his practice, when he was a senior in medical school. The meeting place was Rhode Island Hospital. On September 3rd of this year they will have been married 25 years.

It won't come as any surprise that this busy obstetrician (he delivers about 350 babies a year, just about one a day) loves his profession and his specialty, and is a devoted advocate of the advantages of modern obstetrics and of full-service hospital maternity care. In spite of current day experiments with home deliveries, which can be satisfactory, (but not always), the "safest way is in a hospital". As Chief of Obstetrics and Gynecology at Kent County Memorial Hospital he is proud of the advanced back up services for the high risk population and the close cooperation that exists between Pediatric, Anesthesia, Radiology-Ultrasonography, and Laboratory Departments there. About 5 per cent of all deliveries fall into the high risk category. Because of his reputation, however, referrals bring Doctor Nesbit's way high risk cases to a number amounting to almost 10 per cent of his practice.

He says he could make use of a midwife's services, though, particularly if his wife would decide to become one — and take all calls from midnight to 8:00 am!

On the subject of abortions, the Doctor becomes serious again. He does not perform them. Yet, he is keenly aware that the demand for abortion goes back as far as history, and if a society does not provide opportunities for safe and effective performance of the procedure, it will inevitably be performed by unsafe and ineffective methods. The Doctor recalls a recent case of a 14-year-old girl who aborted by an "old wives'" method, which caused her to require a hysterectomy. To help prevent this kind of tragedy, the Doctor believes that organizations such as Planned Parenthood should have the full support of the medical community. At the same time, he advises education to prevent abortion from becoming by any means a "treatment of choice". Approximately 10 per cent of married couples in the United States today are infertile, and there are not enough babies available to adopt by those who would like to do so, which adds a sociological complexity to the problem of unwanted pregnancy and abortion, compounding the moral and medical issues.

It was a warm sultry morning a few weeks back when Doctor Nesbit stopped by at the Rhode Island Medical Society to chat and allow us a few snapshots. He was just out of the hospital from delivering two babies, a boy and a girl, both healthy. This happened to be one of his busier times, which can come unexpectedly; during the previous two weeks he had had only three full nights of sleep. When the demands of medical practice slacken a little, his favorite pastimes are sailing, travelling and reading. He recently finished Barry Goldwater's autobiography and is now in the middle of *Proteus*. Yet, his pleasure in avocations doesn't compare with his excitement, he couldn't disguise, about his vocation. It seems that even with an average of one delivery a day throughout the year, the experience of assisting new life never pales. ■

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occupancy September 1, 1979

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SNAPSHOT ALBUM . . . ANNUAL MEETING 1980

Charles L. Hill, MD

(l-r) George L. Engel, MD, Chapin Orator; Mayor Vincent A. Cianci, Jr.

(l-r) Stephen J. Hoye, MD; Herbert F. Hager, MD

(l-r) Peter L. Mathieu, Jr., MD; Charles L. Hill, MD

Gathering of members and guests

(l-r) Charles E. Millard, MD; Charles L. Hill, MD; Peter L. Mathieu, Jr., MD

Administrative Reports . . . Meetings of Officers and Staff

Wednesday, June 18, 1980 . . . heard report by the President on the Blue Shield Board meeting held June 12, 1980 . . . discussed the 1974 survey by the AMA of the organizational structure of the Rhode Island Medical Society; this document is available to members upon request . . . received a request from the Governor and RI health department director, Joseph E. Cannon, MD, for suggested appointments to the Patient Qualification Review Board, which will oversee a newly legislated controlled substance research program; three physicians and one pharmacist recommended for appointment are Sze Kim Kaan, MD (oncologist); Joseph Dowling, MD (ophthalmologist); Melvyn Johnson, MD (psychiatrist); Thomas Gibson, RPh (pharmacist) . . . considered RI health department request for comment on proposal for appointing regional subcommittees to the Statewide Health Coordinating Council (SHCC); the request was referred to the Delivery of Medical Care Committee, Charles E. Millard, MD, Chairman, to present recommendations to the President . . . developed further membership promotion stragegies . . . considered a request for support of revision of state laws on acupuncture; a position paper on the subject was finalized June 27, 1980.

Wednesday, June 25, 1980 . . . guests of the meeting were Rhode Island Department of Health staff members William J. Waters, PhD, Assistant Director — Health Policy; Bruce C. Kelley, PhD, Chief Office of Health System Planning; and Donald C. Williams, Supervising Health Planner, Office of Health System Planning . . . discussed criteria for designation of primary medical care manpower shortage areas (PMCMSA) and application process by which regions obtain National Health Service Corps (NHSC) personnel . . . discussed cooperative strategies between the Rhode Island Department of Health and RIMS to predict potential shortages and to attract physicians to regions in which they are needed . . . next meeting with Department of Health officials will be August 6, 1980 to which presidents of district societies are invited . . . discussed the possibility of a Society endorsed statewide fee collection system . . . heard update on recent proceedings of Statewide Health Coordinating Council . . . referred request for information on Catastrophic Health Insurance Program (CHIP) to Joseph E. Caruolo, MD . . . heard a report on rental sales strategies for the Cooper property by Howard E. Lawton, staff member assigned to rental of this property; the Cooper Property Committee will pursue issues with the Society's attorney . . . reviewed routine RIMS correspondence.

Wednesday, July 2, 1980 . . . discussed the growing nursing home shortage situation in Rhode Island and ways the Rhode Island Medical Society should address the problem . . . authorized up to $200 in expenditures by Paul B. Metcalf, Jr., MD for collection of data pertaining to nursing home facilities in Rhode Island . . . discussed the importance of CAT scanning in the delivery of quality health care, and ways to assure its availability to patients . . . decided on a Fiske Fund Essay Competition topic for 1980, "Medicine and Regulatory Law: Is Rationing Inevitable?"

Wednesday, July 9, 1980 . . . Heard a follow-up report by Howard E. Lawton on attempts to rent the Cooper property and on miscellaneous legal and financial factors affecting management of this asset . . . heard a report from Paul B. Metcalf, Jr., MD on the initial meeting of the Blue Shield Liaison Committee held July 7, 1980 and plans for this committee to keep the membership informed on Blue Shield matters and to improve the relationship between the Blue Shield management and board and the Rhode Island Medical Society.

Cave ab Homine Unius Libri!

Louis Vito, MD
Richard Perry, MD

"Be cautious of the man of one book!" To this old Latin admonition I would add — especially a medical book. We in medicine are so preoccupied with the practice of medicine that most of us have hardly noticed, much less responded adequately to, those who criticize and want to change our health care system.

Devotion to our practices consumes most of our working hours. Professional activities such as self-education and reading medical journals must be squeezed into our work week. Leisure time, when it comes, is devoted to our families, hobbies and exercise. It is difficult for us because of lack of time or because of fatigue to become interested in other issues not closely related to our specialties. Yet, those outside the health care system are all the time making plans to change the amount of health care delivered, the way it is delivered, and even its very substance. Because of our complacency, the system is being changed without our input. We are by default losing opportunities to influence the future of health care delivery.

Most will agree that the complexity of the health care industry in our country makes simple solutions impossible. We in medicine have our own opinions and naturally wish to protect some of our own interests. On the other hand, those not involved in patient care representing health consumers, third party payors, government, and industry have legitimate concerns about the quality of health care as well as its cost. In this setting, it is clear that doctors cannot practice medicine autonomously. It is equally clear that with the multiplicity of opinions and interests, it is easy for the less vocal or less organized to be ignored or unheard. Some would take exception to my placing physicians among the "less vocal" or "unheard". However, as events affecting medicine have unfolded in this state, this is exactly our status. Do you think the Rhode Island Medical Society is visible? Is the physician visible? Who speaks for the medical

(continued)

Two-Day Conference: Medical Aspect of Sports

The University of Rhode Island conducted its Fifteenth Post-Graduate Conference on the Medical Aspect of Sports at Kingston Thursday and Friday, July 17-18, 1980. Formal proceedings began at 8 am, Thursday morning, with greetings from URI President Frank Newman and Rhode Island Medical Society President Peter L. Mathieu, Jr., MD. The Conference, one of the more outstanding of its type in the nation, was supported by a grant from the Merck, Sharp and Dohme Post-Graduate Program.

Designed for physicians, trainers, coaches and physical education instructors at all levels, the Conference featured a broad and intensive view of present-day concepts for the prevention and treatment of athletic injuries. Two days of lectures, panel discussions and demonstrations were co-sponsored by URI, the International College of Surgeons, and the Rhode Island Medical Society.

Among the experts who addressed the participants was A. A. Savastano, MD, Orthopedic Surgeon-in-Chief (Emeritus) at Rhode Island Hospital; URI Orthopedic Surgeon; Clinical Professor of Orthopedic Surgery (Emeritus) at the Brown University Medical School; and a world-recognized expert in his field.

URI staff persons on the program included team physician Joseph Fitzgerald, MD; head trainer Tom Dolan; associate trainer Mike Rule; women's basketball coach Nancy Langham, and former trainer Earle Perkins, now of the Rhode Island Interscholastic Injury Fund.

Topics included definitions of sports medicine, the human heart and the athlete, injuries to well known athletes, diagnosis and treatment of heat exhaustion and sun stroke, conflict of interest between the physician and the team, and evaluation and care of the unconscious athlete; also acute head injuries, liability in sports, diagnosis of the acutely injured knee, ligamentous problems of the knee, role of arthography and arthroscopy in evaluating the acutely injured knee, rehabilitation of the knee from a trainer's point of view, proper use of physical therapy in athletic injuries, the coach's finger, stress fractures in athletics, rehabilitation of the injured athlete, upper extremity problems in the throwing athletes, conservative and surgical treatment of acromioclavicular injuries, diagnosis and treatment of sternoclavicular injuries, also, prevention of sports injuries in children, diagnosis and treatment of runners' problems, use of the Boston Brace in treatment of athletic back injuries, nerve injuries about the neck, rehabilitation of the shoulder, women in sports, preparation of a women's collegiate basketball team, operative arthroscopy, ligament reconstruction, hockey injuries, shoulder pain in athletes, and taping and wrapping demonstrations. ■

Cave ab Homine Unius Libri!

(continued)

profession in the state? The physician through the Rhode Island Medical Society should speak for the profession, and be heard and listened to.

Most who criticize medicine are well-meaning and intelligent people, and much of their criticism is justified and has considerable merit. Their solutions to problems deserve careful consideration and thoughtful reply by *all* concerned. Unfortunately, however, we seriously question whether our opinions count. We wonder sometimes whether anyone is listening to us. In the cacophony of varying opinions, order will prevail if all who wish to can express themselves honestly and cogently and are listened to courteously. Personal bias, animosity, jealousy, selfishness, resentment, and arrogance have no place in discussing problems of such magnitude as those related to health care delivery. We must be committed to excellence. Our futures and those of our patients depend on it.

Although it is impossible for each individual physician to be heard, there are existing channels through which collectively we may express ourselves. The Rhode Island Medical Society must perform the role of answering critics and presenting lucid and constructive solutions to problems. However, it needs all our participation and support.

A political organization, the Rhode Island Medical Political Action Committee (RIMPAC), is a vehicle for us to support candidates for public office. Amazingly, involvement in this organization by the doctors of Rhode Island has been poor, both in active participation and in financial support. Indifference or "waiting for someone else to do it" isn't going to work anymore. Our critics are too strong and too well-organized. We must be equally strong and well-organized if we are to be heard. If we can't give our time, we should support this organization with our ideas and money.

We must support unbiased and honest candidates and politicians who will at least hear our thoughts on issues. We don't want them to agree with us or do as we tell them, but we would appreciate an open mind and a fair hearing. We can no longer be a profession of "one book", that is, the medical book. Educating ourselves in the sociology and economics of medicine is imperative. Our critics deserve well thought out rebuttals without rancor.

Let no one mistake our motives. We are a profession dedicated to quality medical care. We are willing to change if change results in better patient care, but we will not be coerced into accepting any change which is an obstacle to excellence. Let's take our noses out of the medical books long enough to look around and see our profession under attack. We need to respond with a strong and organized voice. Support RIMPAC now or do not complain later. ■

One Sentence Essay

A billion here, a billion there. Pretty soon it runs into real money. . . . the late Senator Everett Dirksen

RIMS Position Paper on Acupuncture Regulations

The Rhode Island Medical Society, having been exposed to proposed rules and regulations regarding the practice of acupuncture, after careful deliberation, must regrettably object to them, and respectfully request that in the best interest of the citizens of Rhode Island the pending legalization of acupuncture be shelved.

We feel that the matter is urgent, because it has been brought to our attention that various commercial acupuncture interests are operating with complete obliviousness to the traditional virtues of medical practice, namely, concern for the safety of the patient and service to the public.

Our major concerns are as follows:

1) What are the credentials of the newly formed Rhode Island Board of Acupuncture to pass judgment on the qualifications of a non-physician to practice acupuncture. We are not opposed to the incorporation of acupuncture into medical practice. However, we would strongly urge the newly formed Board to wait, to re-evaluate, and to present to an experienced panel the reasons for making specific recommendations.

2) We note that the Board intends to license the practice of acupuncture independent of the main body of medicine. We regret this move as we believe that this will lead to splintering and devisiveness. Whereas a major thrust in contemporary medicine has been towards team effort and interdisciplinary approaches, we believe that the proposed regulations will tend to fragment the continuity of medical care.

3) We find objectionable the title "Doctor of Acupuncture". We believe that the new Board of Acupuncture has seriously exceeded its authority in grandiosely assuming the role of an accredited academic institution. The term Doctor should be granted only by an appropriate accredited academic institution. This misuse of the term is misleading and probably illegal. We seriously urge that the term "Doctor of Acupuncture" be stricken.

4) To date, qualified physicians have been denied the opportunity to utilize acupuncture as part of their total patient management in Rhode Island. The suggestion is made that physicians may not be permitted to utilize their acupuncture skills under the newly proposed regulations. We would find this prohibition to be completely unacceptable.

5) On behalf of the public, we request disclosure of the basis whereby the current board has been selected.

6) We are horrified to learn that no provision has been made by the Board of Acupuncture to protect acupuncture patients against the danger of contracting infectious hepatitis as a result of treatment.

7) In light of the recent evidence of commercialism in acupuncture practice in Rhode Island, we consider that it is imperative to assure that citizens are not being exploited. We urge that a careful scrutiny of the credentials of applicants to practice acupuncture be made by a responsible board that is accountable to various agencies, including the Rhode Island Medical Society.

8) Before we can accept any of the recommendations of the Board of Acupuncture, we would like to have some evidence that the Board is aware of the recommendations of the Rockefeller Commission and the licensing requirements of New York and Nevada. We consider that the earlier licensing requirements of a California "Certified Acupuncturist" (CA) are totally unacceptable. We believe that both Nevada and New York have provided reasonable safeguards.

9) We believe that it is in the best interest of the citizens of the state for the criteria for licensing to be available. We point out that there are many levels of training, and that acceptable academic training levels should be published.

Needless to say, we will be happy to cooperate toward constructive resolution of the above concerns. We would also point out that ignoring the rightful interest of organized medicine in this matter would seriously offend the rank and file of physicians and have a deleterious effect upon the future of acupuncture in Rhode Island.

The above paper was submitted to the Rhode Island Board of Acupuncture on June 27, 1980.

Ocean State IPA Begins Second Phase

The Ocean State Master Health Plan, a statewide prepaid health program sponsored by a group of Rhode Island physicians, is about to conclude its first phase of development. During the past several months a large number of physicians from across the state have taken the leadership in providing the necessary capital to commence operations. In addition to excellent geographic dispersion, the "founding" physicians represent a wide cross section of medical specialities. According the IPA President, Dr. Charles L. Hill, the second phase of development is scheduled to begin August 1, 1980. This phase will consist of a general mailing to all physicians requesting their affiliation with the Plan. A major strength of the IPA model is to preserve the patient-physician relationship that currently exists. Consequently, each Plan enrollee will be able to select his or her own physician from those choosing to affiliate. Once the provider network consisting of physicians, hospitals, pharmacies, labs, and other services is in place, the Plan will be introduced to representatives of labor and industry. The Ocean State Master Health Plan is targeted to become operational in late 1980.

Aches and Pains . . .

• Joint Commission on Accreditation of Hospitals (JCAH) surveys scheduled in Rhode Island for the period July thru September, 1980 include John E. Fogarty Memorial Hospital, Kent County Memorial Hospital, and Westerly Hospital.

• CHAMPUS now authorizes payment under some conditions for physicians who stand by at births even though their services are not used. Standby charges may be authorized when the delivery is expected to pose some threat to the infant, as in the case of a Caesarian section or other high-risk delivery. CHAMPUS figures show that 23 per cent of deliveries today are expected to be of the high-risk type and require the services of a standby physician.

• By an arrangement with the government and the carriers handling Medicare Part B, Metropolitan Life Insurance Company has developed a special claims processing system for the large number of its clients who are General Motors retirees or surviving spouses. The physician or other provider files all claims directly with Metropolitan using the company's standard billing forms. Metropolitan pays the provider the reasonable and customary fee with no deductibles and no copayments; and seeks reimbursement from the Medicare carrier for services not covered by the company policies, saving the provider the need to do this.

• A recent Philadelphia court ruling says that a PSRO is not a federal agency and is therefore not subject to the Freedom of Information Act. A Philadelphia hospital filed suit in 1979 against the Philadelphia PSRO after refusal of its request under the FOI Act for virtually all physician and hospital information from every hospital in the city.

• Benign and malignant lung tumors can be distinguished through a new technique that avoids surgery, developed at Johns Hopkins Hospital. Analysis of computertomography scans for calcium levels enables physicians to rule out cancer in two-thirds of benign tumor cases.

• The maximum benefit available under the AMA's Group Term Life Insurance Plan has been raised to $200,000 — twice the previous maximum. For further information call: outside Illinois (800) 621-0780; in Illinois (312) 648-6940.

• The US Defense Department has announced that, effective October 1, 1979, it was extending CHAMPUS benefits to cover abortions. At the same time it issued a directive excluding from CHAMPUS coverage cosmetic, reconstructive and/or plastic surgery.

• The Health Care Financing Agency (HCFA) has published a new economic index for the 12-month period starting July 1, 1980 for payment for physicians' services under Medicare Part B. The new index carries an 8.15 per cent increase over the one used for the period which ended June 30, 1980.

• The 7th AMA State Health Legislation Meeting will be held January 4-7, 1981, at the Sonesta Beach Hotel and Tennis Club, Key Biscayne, Florida. Details will be available soon.

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PRESIDENT'S CORNER

Health Care Finance: A Macro-Economic Look: Part II

Peter L. Mathieu, Jr., MD

The health services provided to the public at any given time are the result of the interaction of three major elements in society: (1) the medical care system, which is based on current understanding of health and disease; (2) cultural and epidemiological concepts; and (3) the economic system, which determines how health care is paid for.

Several of the more important reasons for the explosive increase in health care costs are the following: (1) general inflation, which has effected the cost of every aspect of health care delivery; (2) consumer belief that care in tertiary care hospitals is better than that provided in primary care hospitals; (3) the very complex nature of health care delivery; and (4) federal government intrusion, without state government involvement, in the health care delivery system.

As an example of the increase in health care costs, let us examine the marked increase in hospital costs. This is caused by increased labor costs, excessive numbers of hospital beds, increased costs of hospital goods (50 per cent above that of other goods), technological improvements that require increased capital expenditure and more skilled labor, and increased demand for hospital services because of the availability of third party reimbursement. Third party payers do little to encourage economy, because their payments are based on costs. Thus, hospital administrators have little incentives for efficiency, such as by holding down occupancy or reducing length of stay. Government regulation increases costs, since federal, state, and local regulations make it necessary for hospitals to use funds and personnel to insure that they are adhering to the regulations. New York state estimates this to be 25 per cent of total costs. The ease with which hospitals can borrow to maintain cash flow or gain additional operating funds is another factor, since some third party payers reimburse for the interest on such loans. Hospital programs for quality assurance, such as the Professional Standards Review Organization (PSRO) and the Medical Care Evaluation (MCE) Program, increase the costs even though some may be cost-benefit effective.

Consumer expectations merit attention. The hospital setting that the patient demands is often the most expensive type available. Consumers expect expensive technology and expensive medical specialists to handle their problems. This tendency is encouraged by third party payments for these services so that there is little "out-of-pocket" expenditure.

The very nature of the health care delivery system itself is a significant factor. The system is immune to the law of supply and demand. Demand will always exceed supply. In this system, the medical provider may control demand by determining the nature, the quantity, and the duration of services. Another factor is the division of authority in the hospital, where considerable power rests with the physician who uses the hospital to care for his patients, while the administrator of the hospital must actually provide the services. The administrator may have no control over the physician who demands and gets expensive technology that may not be cost effective.

The state and federal legislators have by the passage of many laws and by rules and regulations numbers of hospital beds can be attributed to the Hill-Burton Act of 1946, which encouraged communities to build and expand hospitals by providing federal funds. In the 1960s it was the federal

government that lavished money on research programs and helped develop much of the high cost technology that we have today. The passage of the Medicare-Medicaid Act of 1965 (Titles 5, 18, and 19) produced an explosion in the total expenditures for health care. These supplements to the Social Security Act of 1936 were supposedly promulgated to aid the poor, the working poor, and the elderly.

Pertinent to this discussion is the concept of the "zero-sum society" proposed by Lester C. Thurow, professor of economics and management at the Massachusetts Institute of Technology. In his analysis of some of the critical problems facing the United States in the decade ahead, he proposes that there are effective solutions to our major economic problems, health care systems, energy, inflation, over-regulation, lagging productivity, and slow economic growth. But who gets what? He makes the point that technological progress and government intervention in the economy are likely to benefit most, but will nevertheless harm some. There is nothing new about this. American society has always had a "zero-sum" element, as must any society which contains a variety of economic interests. What may be new, however, is the heightened ability of interest groups to prevent the political process from adopting and carrying out policies that would serve the national interest at some cost to them. America's political institutions were designed to blend the multiplicity of economic interests in order to minimize the danger of a self-interested majority suppressing a minority. Inevitably, the protection thus provided to minority interests will sometimes enable them to delay policies that are in the public interest. The seriousness of the newfound congressional and executive branch belief in cost-benefit analysis and regulatory reform is laudatory.

In this connection Brozen's Law is significant. Brozen's Law is simply this: "Look first for the existing regulation that is causing the problem and abolish it before instituting a new regulation."

The state of federal legislators have by the passage of many laws and by rules and regulations expanded such services as renal dialysis and mental health and psychiatric care, based on the unpromising idea that regulatory decisions will be improved by centralizing the decision making within the government. The government does not distinguish between efficient and inefficient regulatory redistribution. A simple approach to correcting these market and regulatory failures may be to require that all regulations pass a cost-benefit test. Perhaps a system in which consumers, employers, and third party payers work in harmony to assure cost-benefit effectiveness would be feasible.

There is no way that a health care system involving government control of private expenditures by the Certificate-of-Need (CON) mechanism could be successful. It is my belief that regulation has gone amok. For evidence I cite section 504 of the Rehabilitation Act of 1973. Providing door-to-door transportation from the patient's home to the doctor's office for ambulatory care makes more sense than spending billions of dollars in retrofitting existing bus and urban rail systems to provide for the handicapped.

The Certificate-of-Need (CON) legislation contained in Public Law (PL) 93-641 has not controlled inflation in hospital costs and may in fact have resulted in higher capital expenditures. Most CON laws require certification of all projects costing $150,000 or more. Prior to enactment of PL 93-641, most states relied on area-wide comprehensive health planning agencies to conduct initial reviews and submit advisory opinions to state agencies that would issue final opinions. This process has been retained under PL 93-641 with the Statewide Health Coordinating Council (SHCC) conducting initial reviews and in turn advising the State Health Planning and Development Agency (SHPDA).

At the present time SHCC and SHPDA are turning their attention to the health care industry by institution of controls such as CON. Whether in time these agencies will attain their various and conflicting ends cannot as yet be ascertained, but in the view of your president and based on studies of regulatory mechanisms there is little reason to be optimistic.

As health care costs in 1980 will approach and probably exceed the two hundred billion dollar mark, approaching 10 per cent of the gross national product (GNP), observers of almost every segment of society are becoming increasingly alarmed over the high cost of health care. The health care industry is now the third largest, after agriculture and construction. Why should the public be concerned about these tremendous costs? 1. The excessive money spent on health care means less money for other, perhaps equally important, programs such as education. 2. The Social Security Administration could use to advantage part of the funds now drawn off by Medicare for strengthening the retirement part of its program, which is having serious financial difficulties. 3. Up to a certain point funds used in health care may benefit our health. Just where the point of departure is is difficult to determine because of the fragmented method of compensation for health care. 4. Excessive health care costs eliminate some programs for the low income and elderly segments

of our population. 5. As inflation increases and health care costs rise, there will be less money in the consumer's pocket for other necessities, much less luxuries. Further, increasing health care costs fuel inflation. 6. Excessive costs may reflect an excess of health care that is more harmful than healing. 7. As health care costs increase, the hidden cost of an employer's payments for these fringe benefits are reflected in the increased cost of goods and services to everyone, as well as increased state and federal taxes. 8. As health care costs rise, providers may take a larger and larger share of available income, possibly causing a maldistribution of income. The concern of doctors and patients for the quality of medical care is a likely factor in the increasing costs of health care.

Determining an area's health manpower needs with accuracy is difficult. Your president emphasizes that appropriateness of medical care in today's very expensive health care system is important. People should be encouraged to visit the appropriate health care provider when in good health, in order to remain in good health. Since 85 per cent of health care costs are spent on 15 per cent of the population, it would be wise for insurers to give attention to this problem. Further, when a person does become ill, it is urgent that he be admitted to the proper level of care and stay only for the time necessary, progressing systematically through the proper levels of health care. The health care system must during the next decade make available all of the kinds of care — quality care — at the most economical level.

We must pay particular attention to reducing the high cost of dying. As a youth I remember very well visiting a poor farm in nearby Moosup, Connecticut, run by Levi and Mary Mathieu. Levi was a carpenter and Mary a registered nurse. The elderly there were happy. They smiled, they worked, they enjoyed life. There was something for everyone to do within his capabilities. Nursing homes today may have technological advantages, but I see very few smiling residents in these institutions, and most enter with a resistance that is not conducive to a happy existence in the sunset time of their lives. I recommend that we improve the care of elderly patients by discharging them to foster homes, especially elderly patients who cannot go to their own homes. Although these foster "parents" must be carefully screened, there has been no dirth of applicants. Day care centers for the elderly, with their clients transported from their homes in the morning and back to their homes in the evening, thus permitting their relatives to work during the day, make sense and are economical.

Hospice care is nothing new. A hospice provides a pleasant home environment for the terminally ill. The hospice movement will grow in the 1980s as our elderly population in Rhode Island increases from 12 per cent (2 per cent above the national average) to some 20 per cent of the population by 1990.

We must work with private groups and general hospitals to improve care for mental patients. It is time to face the fact that the state cannot operate mental health services competitively. Deinstitutionalization is a convenient way to disperse the problem. The next series of tragedies will involve those who cannot "hack it" in the community on their own. We should rapidly evolve a system of private provider-operated facilities, perhaps contracted for by the state and monitored by PSRO.

Proper financing of the health care system must take into consideration the identification of appropriate and achievable goals. The United States has no budgetary approach, because it has been operating on the principle of entitlement; everyone can and should be provided with all of the health care he or she wants or needs. Our finances are finite. I believe in the pluralistic system and a patient's faith in his own doctor. The consumer should be able to make the final decision about health care by selecting his own provider, whether that provider be a "street doctor", an academic doctor, or a capitation system; whether it be a Health Maintenance Organization (HMO), an Independent Practice Association (IPA), or other entity. Remember, from a purely operational standpoint medical care begins with sick people; disease begins with people at risk, and health promotion begins with people who are essentially healthy. It may be argued that 10 per cent of the GNP for health care is not excessive. After food and shelter, good health should be a third priority, a priority that justifies this massive expenditure.

The aim of the health care system should be to maintain a delivery system that is tied less to capital investment. What is needed is a health care system that is flexible and responsive to whatever demographic shifts the future may offer. The state health department and the medical society can with vision accomplish this.

Peter L. Mathieu, Jr., MD
President

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The Trustees of the Fiske Fund of The Rhode Island Medical Society announce the following for the Prize Dissertation of 1980:

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The awarding of prizes and the amounts are made at the discretion of the Trustees. Awards, if any, may vary from a minimum of $200 to a maximum of $1,000. The dissertation will be particularly graded on the basis of original work by the author. The competition is not restricted to physicians. Each competitor for the premium is expected to conform with the following regulations:

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NOTES FROM THE PROGRAM IN MEDICINE

The Southeastern New England Long Term Care Gerontology Center

The Message from the Dean, which has appeared on this page since it was initiated by Doctor Stanley M. Aronson in March, 1973 will be replaced during his absence on sabbatical leave by Notes from the Program in Medicine. The contributors during this period will be Doctor Pierre M. Galletti, Vice President, Division of Biology and Medicine, and Doctor David S. Greer, Associate Dean of Medicine.

The incidence of chronic disease and impairment has risen dramatically in our society as a consequence of our improved capability to prolong life. The group most affected by this phenomenon is the aged whose numbers increase by approximately 500,000 persons each year. Demographic projections show that if present trends continue, one in six Americans will be 65 years of age or older by the year 2030.

Rhode Island has historically maintained an elderly population significantly greater than the rest of the nation; the most recent official estimates project the number of elderly in the State at 124,000 in 1980, which constitutes over 13 per cent of the total projected population. In Providence, nearly 15 per cent of the population is over 65 years of age, according to data assembled by the Rhode Island Statewide Planning Program. Within this population, 37.8 per cent are over 75 years old; 27.5 per cent fall into the 70-74 cohort; and 34.6 per cent are between 65 and 69 years old. Data gathered by the Bureau of Census in 1976 and projected to each state indicated that the income distribution for the elderly in Rhode Island was weighted toward the lower end of the income scale: slightly under 35 per cent of all elderly reported incomes of less than $3,999 yearly; approximately 40 per cent earned between $4,000 and $9,999 annually.

Administration on Aging statistics indicate that 86 per cent of all elderly persons suffer from one or more chronic conditions and a substantial number of these individuals have impairments which are so severe that they seriously inhibit independent functioning. Because of the dependence of this group and the tendency of social technology to lag behind scientific technology, many of these elderly experience undue deprivation in the community or "warehousing" in long-term care custodial institutions. Without reciting the litany of problems that are an outgrowth of this dependence, it is sufficient to say that the plight of the chronically impaired elderly represents a major challenge to our fundamental notions of human rights and personal dignity.

No panaceas loom on the immediate horizon that promise to ameliorate or eradicate the problems of old age. The statistical probability of disease, disability, or both will continue to increase with age; psychosocial losses will probably persist as chronological age advances; and some degree of economic deprivation will be usual to the vast majority of people over 65.

The quality of life of elderly persons may be compromised by a variety of conditions, among which are: (1) Physical or mental health problems which, due either to their severity or to the presence of multiple impairments limit endurance, stamina or capacity to accommodate to the demands of the environment. An example of this is an aged person who has been recently discharged from the hospital; (2) Loss of ability to carry on activities of daily living because of the gradual encroachment of a physical or sensory loss. An example of this is seen in the person who has extreme visual loss or has difficulty in moving about; (3) Gradual erosion of internal motivation and/or external social supports that can lead to personal stress and ineffective social interaction, often exacerbated by tangible problems of housing, economics and isolation. An example of this is the elderly individual who is depressed and, as a direct result, isolates himself from meaningful human contact.

There is widespread dissatisfaction with our society's response to the needs of frail and vulnerable elderly Americans. The Long-Term Care Gerontology Center concept represents a federal initiative designed to give the problem greater visability and generate innovative solutions.

The Brown University Program in Medicine is particularly interested in the concept because of its historical involvement in community research and training, and in the area of long-term care. This involvement is symbolized by the community integrated structure of the Program in Medicine, the establishment of an Institute for Rehabilitation and Restorative Care at the university, numerous programmatic relationships with public and private long-term care providers, and the stimulation of a Rhode Island Rehabilitation Network. Of particular significance to this effort was the development in 1978 of a gerontology consortium composed of five colleges and universities in the Rhode Island and southeastern Massachusetts region; Rhode Island College, University of Rhode Island, Brown University, Southeastern Massachusetts University, and Bristol Community College in Fall River, Massachusetts.

In 1979, Brown University, on behalf of the institutions comprising the gerontology consortium, was successful in obtaining a one year federal grant to plan a Southeastern New England Long Term Care Gerontology Center. The center will be based at Brown but will be integrated with the health care community in Rhode Island and southeastern Massachusetts in a manner similar to the decentralized "Brown model" of medical education which has proved so successful in the past decade. The center's goals are comprehensive and ambitious:

1. *Education and Training:* The development of comprehensive health and social science education and training programs throughout the southeastern New England region that directly involve both educational institutions and the communities they serve.

2. *Service Provision:* The development of an array of community-based program sites that offer a continuum of services to the frail elderly and can support the integration of training, education, research, and service demonstration.

3. *Research:* Encouragement of research that focuses on the needs of the chronically impaired elderly; facilitation of direct incorporation of research findings or innovative delivery techniques into professional education, service delivery, and program evaluation.

4. *Technical Assistance:* Establishment of an information and consultation resource for policy makers, service providers, and educators to assist them in improving the long-term care delivery system for the frail elderly.

5. *Public Information:* Initiation and management of a comprehensive and responsive system to gather, organize and disseminate information regarding the needs of the chronically impaired elderly to professionals and laymen.

6. *Community Relations:* Increasing awareness of the unique needs of minority elderly who require long-term care.

Fortunately, most Americans over age sixty-five are able to maintain themselves independently. The minority of impaired or frail persons is growing, however, particularly in the rapidly increasing segment of people over age seventy-five. Those who need help have earned our concern and support during their more productive years. The Southeastern New England Long-Term Care Gerontology Center will increase awareness of their problems and expedite the development of solutions.

David S. Greer, MD
Associate Dean of Medicine
Brown University

EDITORIALS

It Is Now the Year 2000 in Rhode Island

The growth in nursing home expenditures has been enormous. In three out of the five years ending in 1977 they have been the fastest rising component of personal health care expenditures. Between 1973 and 1977 expenditures grew 88.5 per cent compared with increases in the consumer price index (CPI) of 36.3 per cent and in the gross national product of 44.4 per cent. Public expenditures doubled while private expenditures increased 76 per cent. These increases place major pressures on federal and state budgets — mostly to economize.

In 1977 nursing home expenditures amounted to $13.4 billion, an estimate that excludes many medical services provided nursing home residents such as most physician services. Government expenditures accounted for 54.4 per cent of total nursing home outlays in 1977; private payment accounted for the remaining 45.6 per cent. Medicaid is the predominant public source, accounting for 86 per cent of the 7.3 billion in public expenditures. Medicare accounts for another 5 per cent. Other public sources, such as the Veterans Administration and various state and local programs, comprise the remaining 19 per cent. The public-private split is essentially the same for the financing of nursing home as compared with hospital services (54.5 per cent public and 45.5 per cent private). However, while private insurance accounts for only 1.6 per cent of private nursing home expenditures, it accounts for 35.2 per cent of private hospital expenditures.[1]

In January 1979 Hale Champion, Health, Education and Welfare (HEW) Undersecretary representing the Secretary, described long-term care as the leading health and social problem. HEW had no solution for long-term care at that time. The same report states: "It is generally recognized (that) the 'oldest of the old' are the most at-risk for long-term care. Since this group is growing at a faster rate than other age cohorts, utilization of long-term care will increase. This happens at the very time there is pressure to limit spending for health."[2]

At the present time about 23 million Americans are 65 years old or older — one person in 10 — more than seven times the number (3 million) at the turn of the century. Every day about 4,000 Americans reach their 65th birthday, and approximately 3,000 die — a net gain of about 1,000 additional citizens over 65 years of age. The trend of increasing survival rates and near-zero population growth leads to a projection that by the year 2000 there will be about 33 million "older" Americans, 12 per cent of the population. Extrapolating further, it is estimated that by the year 2030 almost one out of 5 persons, 20 per cent of the population, will be over 65 — many in the 70, 80, and 90 year age groups. This rapid change in the age configuration is the basis for much current speculation about the changing patterns of economic, social, and health needs of the population as we approach the 21st century.[3]

It has been said truly that in the field of health care the only economy is death. If longevity increases, we can confidently expect the per capita consumption of medical care to increase.[4]

If the expenditure increases in recent years are impressive, the future pressure for expansion due to the growth in the elderly population will be even more dramatic. Between 1977 and 2030 the total population is projected to grow by 40 per cent, while the elderly population will more than double. Nursing home use increases dramatically among those over the age of 75, and the proportion of the aged who are over 75 is rising. By 2035 the percentage of the population over the age of 75 is expected to increase from 38 to 45 per cent. By the year 2000 there will be an increase of 54 per cent in the number of residents in nursing homes, assuming the fact that by the year 2000 12.5 per cent of the United States population will be over the age of 65.

Additionally, 88 per cent of the functionally disabled between the ages of 18 and 64, and 70 per cent of the elderly disabled live with others. It has been estimated that for every person in a nursing home there are as many as two persons who are equally disabled living in other settings, mostly at home. The willingness of spouses and adult children to care for their aged and disabled relatives has perhaps been underestimated in the popular press.

However, the concern exists that the willingness and capacity may decrease as a consequence of increasing divorce rates, declining birth rates, the growth of single parent families, and the increasing percentage of women in the labor force.

There is indication of a shortage of nursing home beds for public patients in some parts of the country. The HEW study used data from 1969 to 1973, but the situation is unlikely to have changed, as the growth in the number of nursing home beds has not kept pace with the growth in the elderly population. Between 1973 and 1977 the number of nursing home beds increased by 5.6 per cent, compared to a 12.7 per cent growth in the population over 65. Hence, efforts to deinstitutionalize long-term care patients, now a national trend, will result in ever increasing numbers of patients entering nursing homes. It is projected by demographers that by the year 2000 there will be an increase of 54 per cent in the number of nursing home residents. This projection is based upon the fact that by the year 2000 12.5 per cent of the population will be over 65 years of age and 132 per cent by the year 2030.[1]

Since in 1980 12.6 per cent of the population of Rhode Island is already over 65 years of age, we already have a serious problem and one that must be addressed immediately. We must avoid the pitfall of wasting funds because of the lack of nursing home beds. The lack of such beds and their inappropriate utilization results in the waste of money which is desperately needed for other health care requirements. Statistics provided by the Rhode Island Professional Standards Review Organization (RIPSRO) demonstrate how much money is being wasted in the state in this way. In 1973 the average number of days of delay transferring from a hospital to a skilled nursing or intermediate care facility was 5, affecting approximately 3,000 patients and costing approximately 15,000 hospital days. Figures from the third and fourth quarters of 1979 show the average had risen to about 6 days delay, costing approximately 18,000 hospital days, and the situation is getting worse. Recent preliminary RIPSRO figures for February 1980 show an average of 12 days delay per patient desiring transfer. Even allowing for the fact that some of these extra days are administrative, and not strictly speaking wasted, this is a striking problem, which must be rectified.

In a New York state PSRO report it was recently charged that more than $240 million is wasted each year on care of the elderly. The charge was based on a survey of patients in 289 hospitals. Patients who were well enough to be cared for in nursing homes had to wait an average of 10 weeks before nursing homes were able to receive them. Medicare pays an average of $200 per day for care of the elderly in hospitals. State administered Medicaid pays an average of $50 per day for nursing home care. The $150 per day difference represents the estimated $240 million loss per year. The New York State PSRO pointed out that the problem would take an "astronomical leap" in the coming decade as the number of elderly patients increases.[5]

Since those over the age of 65 presently represent 12.6 per cent of the population of Rhode Island, we can anticipate an even larger "astronomical leap". We shall also have increasing numbers of patients over 75 years, whose need for nursing home services, as Fox has pointed out, increases dramatically.

It is obvious from these data that we do not have the luxury of wasting time trying to arrive at a solution to the problem in Rhode Island. In view of the overwhelming evidence of an "old age time bomb" we should address the issue at the earliest possible moment.

There has been a sharp decline in the number of skilled nursing beds available in Rhode Island. Authorized bed capacities statistics published by the Rhode Island Department of Health, Division of Licensure and Construction show a reduction of 1,044 beds from October 23, 1978 to February 1, 1980 (15 months), a 28 per cent reduction from the high in 1978 of 3,674 beds to the low in 1980 of 2,360 beds. The decrease occurred during approximately the same time that the Medicaid reimbursement mechanism was revised from a formula in which payment is made on the basis of level of care to one in which "per diems" negotiated for SNF, ICF-I, and ICF-II levels are keyed to occupancy. When facilities started to be penalized, they began adjusting their bed capacities to maximize reimbursement. With our increasing aged population in Rhode Island we cannot reduce the number of days in the hospital and at the same time reduce the number of skilled nursing home beds. If there is any hope of reducing hospital utilization, skilled nursing home beds must be available. The old proverb applies to our present situation. "We are being penny-wise and pound-foolish." *We can ill afford to postpone addressing this issue.*

Charles E. Millard, MD
Chairman
Delivery of Medical Care Committee

References

[1]Fox PD, Clauser SB: Trends in Nursing Home Expenditures. Office of Policy Analysis, Health Care Financing Administration. Presented to American College of Physicians, Washington, DC, June 12, 1980.

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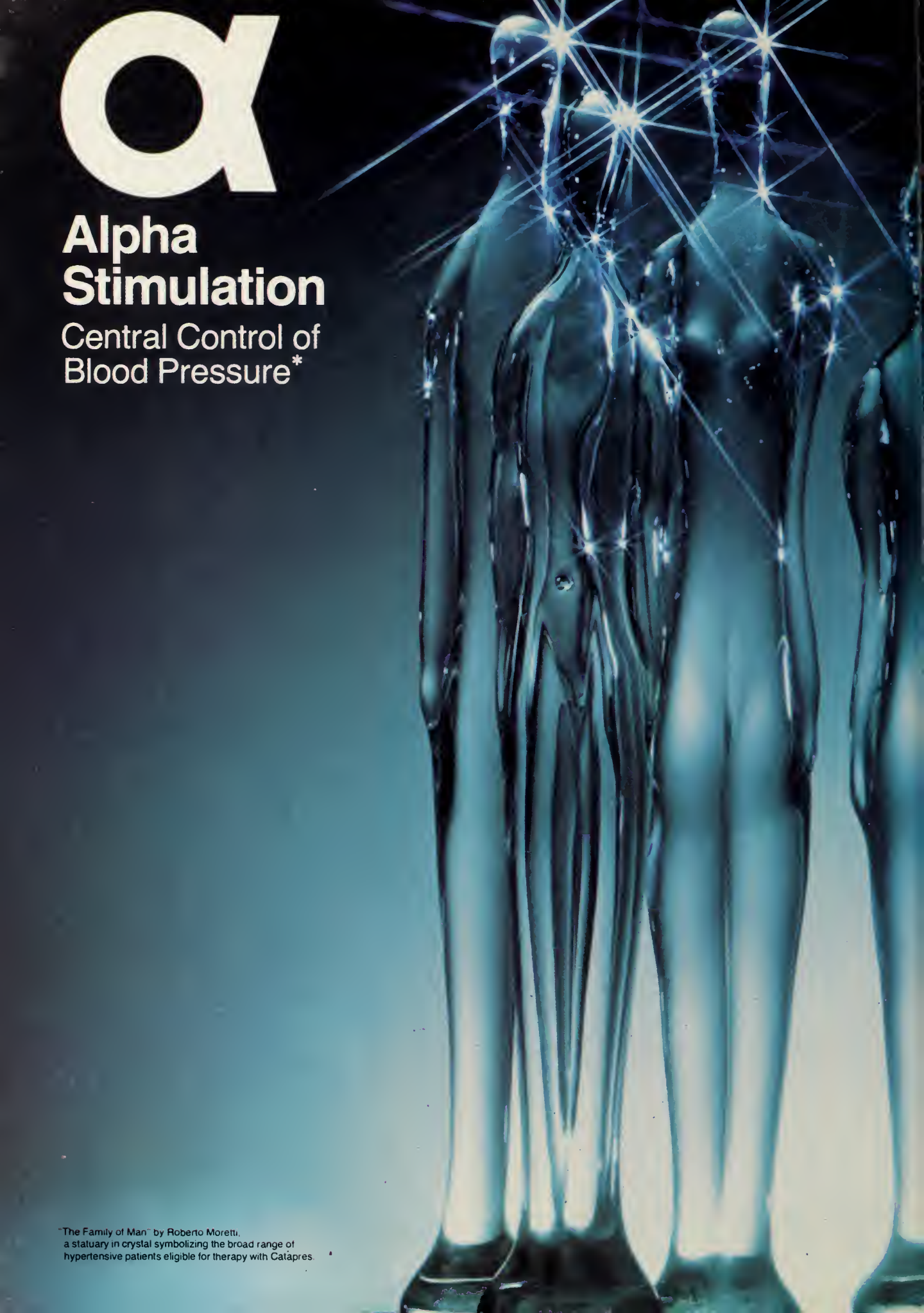

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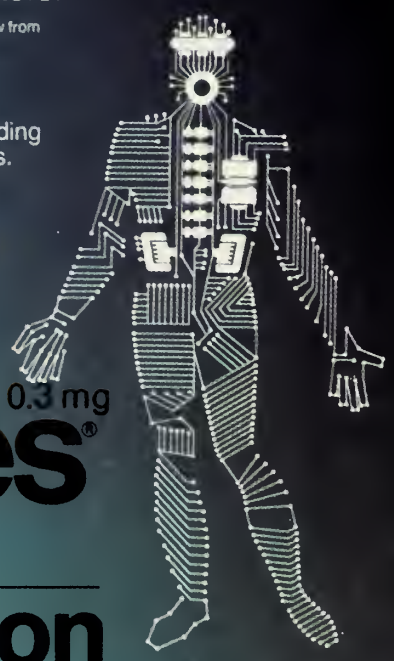
Please see last page for brief summary, including warnings, precautions, and adverse reactions.



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Usage in Children: No clinical experience is available with the use of Catapres (clonidine hydrochloride) in children.

Precautions: When discontinuing Catapres (clonidine hydrochloride), reduce the dose gradually over 2 to 4 days to avoid a possible rapid rise in blood pressure and associated subjective symptoms such as nervousness, agitation, and headache. Patients should be instructed not to discontinue therapy without consulting their physician. Rare instances of hypertensive encephalopathy and death have been recorded after cessation of clonidine hydrochloride therapy. A causal relationship has not been established in these cases. It has been demonstrated that an excessive rise in blood pressure, should it occur, can be reversed by resumption of clonidine hydrochloride therapy or by intravenous phentolamine. Patients who engage in potentially hazardous activities, such as operating machinery or driving, should be advised of the sedative effect. This drug may enhance the CNS-depressive effects of alcohol, barbiturates and other sedatives. Like any other agent lowering blood pressure, clonidine hydrochloride should be used with caution in patients with severe coronary insufficiency, recent myocardial infarction, cerebrovascular disease or chronic renal failure.

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[2]Key Issues in Long Term Care, A Progress Report. Federal Council on Aging, 1979.
[3]Panneton PE, Wesolowski EF: Current and Future Needs in Geriatric Education. Public Health Rep 94:73-79, Jan-Feb 79.
[4]Wilson DL: Time for a New Approach to Canada's Older Population. Can Med Assoc J 122:829-833, Apr 80.
[5]Funds for care of aged wasted, PSRO asserts. Amer Med News:19, 13 Jun 80.

Heshe, Hiser, and Himer

As the women's liberation movement has gained prominence, editorial persons have been plagued with exquisitely awkward new conventions and solecisms. In a recent editorial in a respected medical publication I found the following: "Today's patient expects much more than a diagnosis or a pat on the back, he or she wants specific information and assistance to maximize their health potential."

Aside from the incorrect punctuation and the atrocity "maximize", we note the "he or she" cliche and the ungrammatical "their" in lieu of "his or her". "His or her" appeared several times in the editorial.

Personally, this writer has no problem with the grammatically correct and universal "he, his, and him", (instead of "he or she", "his or her", and "him or her") or such other long-time conventions as mankind and chairman rather than "personkind" or "chairperson".

However, the purists among us are undoubtedly waging a losing battle. This column which claims priority for its unheralded introduction of the term "Elsewhere General Hospital" some years ago, has another neologism to offer the world. This will we hope (not "hopefully") save the English language from the perpetuation of the awkward "he or she" and "his or her". In lieu of them we suggest "heshe" (pronounced "heeshee") and "hiser" (pronounced "hizzer"). The sentence quoted above would read in part, "Heshe wants specific information to maximize hiser health potential".

The War Against Smoking

In the trenches of the war against cigarette smoking it is easy to become pessimistic. Victories are usually so few—albeit precious—that it is easy to become discouraged.

One staffer from a volunteer health agency confessed recently that the success rates from the agency's quit smoking activities were so low that volunteers were losing interest, dropping out of the war. At a recent Quit Smoking Program conducted by the Interagency Council on Smoking only two of the 18 persons enrolled in a six-week program succeeded in quitting cigarettes by the program's conclusion. And on another front—the public school arena—one seasoned veteran of the war noted sadly and soberly that there was a body of opinion which believed that conduct of the war should perhaps be best returned to the teachers and school nurses for imposition of "traditional" teaching methods. It was suggested that perhaps it would be best to back off from such innovative approaches as the cross-age teaching program of the Rhode Island Interagency Council on Smoking. The program involves the recruitment and training of high school students—non-smokers—who later go out into the field to present the plain facts of cigarette smoking to impressionable fifth graders arriving at the age of experimentation. Fifth graders seeking role models. Fifth graders groping with methods of making decisions which effect their lives.

But what impact does all of this and other related educational activity really have? Looked at coldly and analytically, the figures—the numbers—can be a source of disillusionment and discouragement, particularly for the battle weary in the trenches.

The numbers. They can also be a source of challenge and encouragement. In a paper appearing within these pages, Robert J. Marshall, Jr., a Project Evaluator, Community Health Section, at Brown University's Program in Medicine, reports on the extent of cigarette smoking among public school children in Rhode Island.

Data for his paper, he points out, was gathered in conjunction with the School-Based Smoking Project of the Rhode Island Department of Health's Cancer Control Program (RICCP). The project was

developed and conducted through the joint efforts of the Interagency Council on Smoking and the American Cancer Society, Rhode Island Division, and had as one of its goals the reduction by "10 per cent per year the proportion of students smoking cigarettes in three target school systems."

Drawing from a sample group of more than 2,600 public school children of grades six, eight, ten and twelve, researchers gathered data between December, 1978 and April, 1979. Among the facts produced were these:

- Fourteen per cent of male students and 21 per cent of female students responding smoked cigarettes. Female school children in Rhode Island, it was concluded, smoke in greater proportion than their national counterparts (15 per cent).
- Rhode Island teenage females begin smoking earlier than Rhode Island teenage males.

The survey developed some compelling information. For example, the presence of a smoking parent can increase by 50 per cent the likelihood that a child will smoke. And even more astonishingly an older sibling who smokes will *quadruple* that likelihood. Children whose friends smoke are themselves much more likely to smoke than children whose friends do not smoke.

These and other equally interesting observations by Marshall, a PhD candidate at Brown University's Department of Sociology, lead him to the conclusion that cigarette smoking—the initiation of it—"is not merely an individual psychological phenomenon." Rather, smoking patterns of family and friends, as well as job experiences outside the home all are significantly related to cigarette smoking prevalence. Even school grades have a significant impact on teenage smoking habits, it was found. Marshall's report concludes that "smoking among public school children cannot be reduced simply by educating the individual . . . ."

The report is encouraging because it sheds new light on the magnitude of the problem of cigarette smoking among public school children. The message to public health agencies and educators alike is not that we return to "traditional" methods. Rather, the challenge posed by Marshall's report is that new and more sophisticated approaches be developed to cope with a problem much more complex than first believed. Perhaps this realization is the most important aspect of the Cancer Control Project in Rhode Island.

Edward B. Powell
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Rhode Island Interagency Council on Smoking

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ADVERSE REACTIONS: *Cardiovascular*: Palpitation, tachycardia, elevation of blood pressure, precordial pain, arrhythmia. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride. *Central Nervous System*: Overstimulation, nervousness, restlessness, dizziness, jitteriness, insomnia, anxiety, euphoria, depression, dysphoria, tremor, dyskinesia, mydriasis, drowsiness, malaise, headache; rarely psychotic episodes at recommended doses. In a few epileptics an increase in convulsive episodes has been reported. *Gastrointestinal*: Dryness of the mouth, unpleasant taste, nausea, vomiting, abdominal discomfort, diarrhea, constipation, other gastrointestinal disturbances. *Allergic*: Urticaria, rash, ecchymosis, erythema. *Endocrine*: Impotence, changes in libido, gynecomastia, menstrual upset. *Hematopoietic System*: Bone marrow depression, agranulocytosis, leukopenia. *Miscellaneous*: A variety of miscellaneous adverse reactions has been reported by physicians. These include complaints such as dyspnea, hair loss, muscle pain, dysuria, increased sweating, and polyuria.
DOSAGE AND ADMINISTRATION: Tenuate (diethylpropion hydrochloride): One 25 mg. tablet three times daily, one hour before meals, and in midevening if desired to overcome night hunger. Tenuate Dospan (diethylpropion hydrochloride) controlled-release: One 75 mg. tablet daily, swallowed whole, in midmorning. Tenuate is not recommended for use in children under 12 years of age.
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References: 1. Citations available on request from Medical Research Department, MERRELL-NATIONAL LABORATORIES, Cincinnati, Ohio 45215. 2. Hoekenga, M. T., O'Dillon (Dillon), R. H., and Leyland, H. M.: A comprehensive review of diethylpropion hydrochloride. In, Central Mechanisms of Anorectic Drugs, S. Garattini and R. Samanin, Ed., New York, Raven Press, 1978, pp. 391-404.

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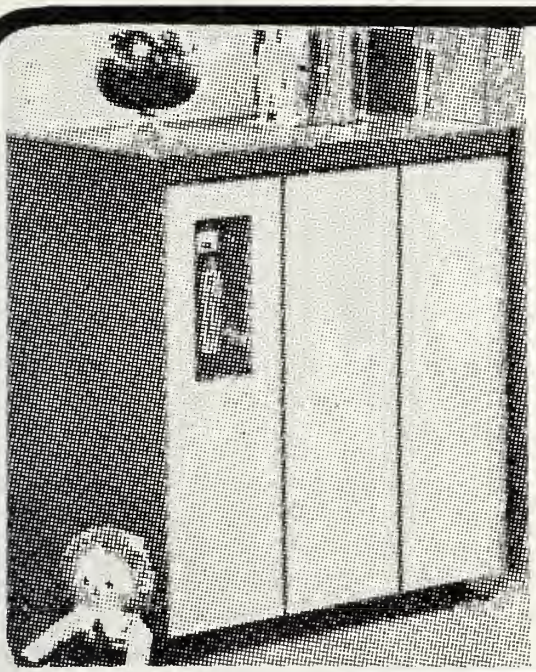

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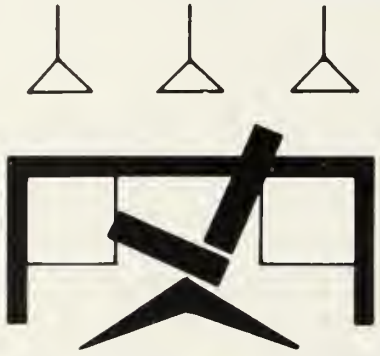

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President's Address 1980

We Must Give Up Age-Old Paternalistic Attitudes To Become Informed Advocates for Our Patients

Charles L. Hill, MD

During my years of private practice, I have observed disturbing changes in society and the practice of medicine. I believe these changes to be symptomatic of the confusion in values which we are witnessing as life has become increasingly complex, both technologically and politically. A country which allows free enterprise and competition now questions success and develops a suspicious air toward those who are bold in their actions. Refusal to be accountable for failure, and yet desire to bask in the joys of success, is certainly a change in our New England ethic.

The increasing tendency to blame others for a natural catastrophe, or true accident, is placing a greater burden than ever on the government. The reaction of society is to discard the old system without thought to the ramifications of revolutionary change. Our energies would be better directed to protect those values which are good in our system, and yet try not to be so blinded by our own selfish interests that we fail to recognize the need for long-range goals and modifications of the system necessary to attain them.

We who have been trained in the actions of the human body and the mind must recognize the forces of human nature causing the demands which are increasingly placed upon us. We must make ourselves aware of the psychological reasons stimulating antagonism so we can successfully break down those irrational barriers to rational compromise.

Historically, economic turmoil has created confusion on the part of the elected officials of this democratic society. Historically, with each recession and inflation, various methods of combating the unpopular fiscal instability are tried. Historically, none of these methods has proven of value. These elected and appointed officials some from sincere humanitarian motives, others from politically opportunistic motives, and others from sheer frustration, attempt simplistic maneuvers with the hope of strengthening the economy.

The health care industry has become one of the more obvious groups to blame and attack. The "spiraling costs of health care" has become a byword of the social planners. Certainly, this industry contributes to the problems of the economy, but, unfairly, it is indicted by society for an unrealistic chare of blame. Politics, as they are, do not allow us the time to appeal to a sense of fairness. We deal in an unpopular product — ill health.

I will not, at length, discuss the philosophy of the physician and patient relationship. I would note that this relationship is initiated by the consumer. He is rapidly being educated in the knowledge of available methods of care, and is asking questions, which is a good sign. He often demands from the system more in the way of cost than his illness warrants.

The approach to economically sound health care must consider all aspects — psychological, admin-

Delivered at the 169th Annual Scientific Assembly of the Rhode Island Medical Society, at the Cranston Hilton Inn, Cranston, Rhode Island, May 14, 1980.

Charles L. Hill, MD, President 1979-1980, presently Executive Vice President, Rhode Island Medical Society.

istrative, educational, and research. I believe there are two assumptions made by the political leaders which will forever change the character of medical practice. The first is that medical care is too expensive.

The second revolves around ways to correct this, involving governmental regulation and price control of medical care. I would read to you a passage from a national consumer publication on health planning. "It seems that once again, consumers are being asked to depend on the spirit of volunteerism and altruism of health professionals. We are asked to believe they will band together in an uninterested way to seek solutions to problems resulting in large measure from the basic systemic forces of profit making, status seeking, professional rivalry, secrecy, and insularity. This comes somewhat as a suprise. We thought that such naive notions had been put to rest with the failure of the Comprehensive Health Planning Act, and the Professionals Abuse of Medicare and Medicaid Programs."

Our words and good intentions shall be of no value. Only the results of our actions will speak for us. We saw this to be true in negotiations over the Rhode Island State Health Plan. The fact that our voluntary efforts locally resulted in significant economies gave credence to the suggestion allowing reasonable changes. The time is here for physicians to reassert the leadership which has helped to build a strong health system. To do this will require financial sacrifice by way of donating more free time to committee work, or creating a dues schedule ot allow the hiring of top notch leadership.

We cannot compete with our present structure. We must create a committee of health providers to be abreast of the universal problems. We must strengthen the relationship with individual hospital staff associations to stimulate those changes and practice patterns necessary to effect quality, progress, and economy. We must develop a respectful working relationship with government.

The current jargon addresses long-range planning and tactical intervention. We should create a formal plan for our own society. We are fortunate to have the advice of the A.D. Little Report to use as guidelines. Our SHCC (Statewide Health Coordinating Council) liaison committee, with Doctor Charles E. Millard's leadership, will coordinate the recommendations from district and specialty societies, other areas of provider manpower, including physicians assistants, nurse practitioners, and mid-wives.

The most efficient distribution of these people should be evaluated in an effort to provide reasonable access but not to limit the ability to practice where and in the manner one desires. Included in this section should be a true study as to the amount of care provided by post-doctoral physicians in training. This service to the community presently is not measured. If we do not clearly recognize the changes in the barometer, warning of the coming social tornado, the resulting destruction will be horrendous to us and to the consumer.

We can only achieve a responsible system through unity and accepting some financial responsibility ourselves. The university must come down from the ivory tower, the clinician must remove himself from the parochialism of individual hospital affiliations. We must listen to each other and the community, or the regimentation forced upon us will be irreconcilable with the superior system which unified effort and innovation can create.

In the last analysis, physicians must give up their age-old paternalistic attitudes to become informed advocates for their patients and responsible counsellors to the community.

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Education of Handicapped Children

The Physician Has an Important Role and Responsibility in This Education

S.M. Pueschel, MD, MPH
James P. McEneaney, AB, MEd

The Education for All Handicapped Children Act, Public Law 94-142, enacted in 1975, has been in effect since October 1977[1]. During the past few years, many professionals in medicine and education, as well as parents of handicapped children, have become familiar with the mandate of this law. Yet, there are numerous citizens including physicians who are less well informed of the practical implication of Public Law 94-142 and are not well acquainted with the Rhode Island Regulations Concerning the Education for Handicapped Children[2].

This paper will focus on the essential components of the federal law, Public Law 94-142, as well as highlight the basic elements of the Rhode Island Regulations for the Education of Handicapped Children and how they may affect the medical practice of the primary care physician.

Provisions of the Law

Never before in history has a federal law revolutionized special education as has Public Law 94-142. Under the provision of this law, local educational agencies are required to identify and to evaluate handicapped children including mentally retarded, hard of hearing and deaf children, speech and language impaired, visually handicapped, seriously emotionally disturbed, and orthopedically or other health impaired children. Public Law 94-142 assures that all handicapped children have available to them an appropriate education designed to meet their unique needs. The major provisions of the new legislation are aimed at ensuring the right to education of handicapped children[1]: that they are guaranteed a free public education at no cost to the parents, that each handicapped child be provided an individualized education, that special education must take place in the least restrictive environment, that procedural safeguards be established to ensure parents due process, that in-service training for personnel in general and special education and for personnel providing support services be instituted.

According to this act, state and local educational agencies will be financially assisted to provide the education of handicapped children. By September 1980, developmentally disabled persons aged 3 to 21 must be served unless a court decision rules otherwise. An individual educational program must be developed for each child by the teacher, parents, qualified supervisor, and other professionals. The parents have a distinct role in both the design of the plan and in the placement decision. They are empowered with due process guarantees should they disapprove of the educational recommendations made by the school authorities[1].

Rhode Island Regulations

While Public Law 94-142 has made a significant impact on the education of developmentally disabled children, most of the states have also

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established their respective ordinances which provide local school systems with rules relating to the education of handicapped children[3]. In Rhode Island, the Board of Regents for Education published Regulations for the Education of Handicapped Children in April of 1977[2]. These regulations deal with the definition of handicapped children, the establishment and administration of special education programs including transportation, personnel, procedural safeguards, and support services. Detailed information pertains to the involvement of psychological, social work, occupational, and physical therapy, as well as speech and language services in the evaluation and in the provision of special education for handicapped children. Although the physician's participation is not specifically mentioned, he/she will be interested in the sections of the regulations concerned with screening, referral, and evaluation procedures[2].

Neither Public Law 94-142 nor the state regulations specify the physician's role, which is implied rather than defined. This ambivalence about the place of the health professional in the special education process has left many physicians confused. Yet, as the physician provides care of the handicapped child, he/she will be directly as well as indirectly involved in educational matters of the child.

There will be several services with which the physician will be concerned: identification of children with handicapping conditions, evaluation of their health status, referral to an appropriate evaluation center if indicated, counseling of parents concerning educational programs, and follow-up and longterm care of the developmentally disabled child.

In many instances the pediatrician or family physician will have detected the handicap either in the newborn period or during the child's early development. While many states have been encouraged to pursue the identification of handicapped children in early life, the procedural details are entirely up to the local educational agencies. No particular guidelines relating to the medical involvement of identification are provided. The Rhode Island regulations state "that in order to identify children with suspected handicapping conditions each school system shall conduct system-wide screening programs . . . consistent with that described in the Rhode Island Child Find Plan." While some physicians will be only marginally involved as consultants to the local educational agencies, others will be actively participating in the screening process of Child Find programs.

The pediatrician who has been following a handicapped child will have data available on the developmental progress of the child, his/her handicap, and the general health status which are needed for realistic educational planning. Thus, the physician can be a source of information for the school system.

In the Rhode Island regulations three types of assessments are described: the full, intermediate, and learning disability evaluations. During the full evaluation of the handicapped child, the physician's direct involvement is of primary importance, since "each child shall be given a general medical . . . assessment." The physician will obtain a complete developmental, medical, and social history followed by a comprehensive physical/neurological assessment and specific laboratory tests if needed. The physician will often participate in the subsequent team conference, when he/she will discuss the medical aspects in relation to the overall evaluation and then formulate medical recommendations.

Physician Participation

Some states require the physician's participation in full evaluations only when there is a need for medical input, while others mandate annual physical examinations on every handicapped child[3]. In Rhode Island, the child is to be evaluated "in all areas related to the suspected disability including health, vision, hearing, social, and emotional status . . ." Furthermore, it is stated that children with behavior disorders require a psychiatric assessment and that children who are blind or partially sighted are to be examined by an ophthalmologist[2].

While the original Rhode Island regulations for the Education of Handicapped Children indicated that the evaluation team shall "have readily available to it the services of a licensed medical practitioner", this phrase has been deleted in the revised version. Also, the clause that children with neurologic or aphasic disorders should have both a psychiatric and a neurologic examination has been taken out of the amended regulations[2].

Since the federal law as well as the state regulations assume a high level of diagnostic sophistication, many children with complex developmental disabilities will need to be referred to a child development center or other assessment facility where professionals with special training are available to carry out an in-depth evaluation. Because such evaluation centers are usually overwhelmed with numerous requests for assessment and since such evaluations are expensive, most school systems have developed their own diagnostic teams where children with minor handicaps can be evaluated.

While the physician provides his/her medical

expertise during the overall assessment of the handicapped child, he/she will also be interested in an appropriate placement and an optimal educational opportunity for the child. As an advocate for the child, the physician will guide and counsel the parents on those issues. No mention of medical participation is made in sections discussing the intermediate and learning disability evaluations.

Public Law 94-142, as well as the state regulations, requires that an individual educational program be developed for each child and that this program be monitored and updated annually. There is no requirement for the physician to become involved in the individual educational program planning. Yet, in the development of a realistic educational plan, the child's health and his/her physical condition will have to be taken into consideration. Hence, the physician will often have indirect input in the design of the child's individual education program.

Pediatricians are often asked for advice if parents disagree with the school's educational recommendation. Therefore, it is important that physicians become familiar with the essential elements of the federal law, the state's special education implementation plan, and local education opportunities, as well as the rights of the handicapped child and his/her parents.

Rights of Parents

Previously, when they were in disagreement with school authorities, parents did not have any recourse and their protest often was ignored. The new federal law and the Rhode Island regulations in particular emphasize the rights of parents and give them the opportunity to exercise their own judgement about what is best for their handicapped child. The physician may want to assist parents in this regard.

As a member of society and as an advocate for the child, the physician will at times be involved in monitoring community compliance with the federal legislation and with state regulations as they relate to special education strategies for handicapped children. Physicians may be called upon as consultants at hearings or school committee meetings.

As the role of the pediatrician has changed over the past decades, he/she will need to be prepared to deal more often with behavioral, developmental, and educational aspects in children. Consequently, the physician may want to pursue postgraduate training in the field of developmental pediatrics and developmental disabilities. The need to acquire a better understanding of child development and more effectively to employ methods for evaluating children with developmental disabilities has been stressed in a recent publication by Shonkoff and coworkers[4].

Training Programs

The American Academy of Pediatrics also has become cognizant of the need for further training of primary care physicians serving handicapped children. With federal assistance, the American Academy of Pediatrics has engaged in an in-service training program for pediatricians. The primary purpose of this program is to improve physicians' interpersonal and professional attitudes about handicapped children, to enhance their knowledge about handicapped children, to foster clinical skills relating to handicapped children, and to increase their interaction with the educational system.

The University Affiliated Programs are mandated to train young physicians in the care of children with development disabilities and to offer the trainees a comprehensive experience in the evaluation, management, and treatment of children with handicapping conditions. Physicians who have been trained in such programs will be the experts of the future and will have the knowledge to deal with the many complex issues relating to developmental disabilities including educational strategies of the handicapped child.

Summary

The enactment of Public Law 94-142 as well as the amended State Regulations for the Education of Handicapped Children have marked a new era in the education of children with developmental disabilities. While this novel legislation and ordinances stress the right of the handicapped individual in society to a free and appropriate education, they also challenge physicians to redefine their role in the management of children with special needs and to become more familiar with their educational concerns. The physicians' contribution will be more significant as they become more knowledgeable in matters of child development and the education of the handicapped child.

References

[1]The Education of Handicapped Children Act of 1975, PL 94-142, 20 USC 1401 et seq. Federal Register 42 (163) :42474-42518, 1977.

[2]Board of Regents for Education. Education for Handicapped Children, Regulations of Rhode Island. Adopted April 20, 1977; amended August 3, 1978.

[3]Fitzgibbons PM, Ferry PC: Its the law: Mandatory public education for handicapped children. Am J Dis Child 133:476-478, May 79.

[4]Shonkoff JP, Dworkin PH, Leviton A, et al: Primary care approaches to developmental disabilities. Pediat 64 (4) :506-514, 1979.

Child Development Center
Rhode Island Hospital
Providence, RI 02902

The KDS-3A as a Guide to Diagnosis

Test Is Extremely Useful Guide in Diagnosis and Treatment of Affective Disorders

Patricia Wold, MD

This investigation is designed to test the correlation between scores on the KDS-3A[1] and more recent classifications of Affective Disorder in a Community Mental Health Clinic population. The KDS-3A is a paper and pencil test consisting of 39 questions designed to elicit information on personality traits. Scales measuring specific attributes, such as anxiety, depression, or impulsivity, consist of a series of weighted items. For example, to measure chronic anxiety, six specific questions were each given a value of from 1 to 3 adding up to a possible score of 14 (Table 1). The impulsivity scale consisted of seven questions each of which is weighted from 1 to 3, with the highest possible score being 15 (Table 2). This test was developed by Kupfer, Detre, et al[2] in New Haven where it was evaluated both for reliability and validity.

Kufper's[1] test was originally used on outpatients whose response to medication was known. The data was collected during illness free periods. It seemed to separate bipolar lithium responsive unipolar depression from tricyclic responsive unipolar depression. Bipolar I and bipolar II patients were grouped together inasmuch as there was an insufficient number of the latter. Persons whose diagnosis was in question or who had recently relapsed were excluded. Their sample included 117 of 135 patients originally studied in an outpatient department. They found that responses to specific questions posed to patients measured chronic anxiety and differentiated those unipolar depressions which responded to tricyclic antidepressants from those which responded to lithium (Table 3). Lithium responders, both bipolar and unipolar, had significantly lower chronic anxiety scores than did tricyclic responders.

Their work demonstrated the existence of a group of unipolar depressions which was lithium responsive and which had a family history similar to that of bipolar patients. These patients seemed to be freer of chronic anxiety during illness free periods than were tricyclic responders. It was not clear, however, whether or not these patients would score at intake as they had during the illness free period in which their data were collected. If the chronic anxiety scores were found to be low during acute illness also, the test might be used to diagnose bipolar disorders which might not be immediately clinically obvious.

A pilot study[3] using the KDS-3A test in a Community Mental Health Clinic setting found that responses to the questions do change during medication over a period of 6 months. However, responses at intake to the chronic anxiety and impulsivity scales were predictive of those patients who ultimately responded to lithium and tricyclic medications. In the previous study[3], it was found that persons who ultimately responded to lithium consisted of two groups of people; those having bipolar affective disorder, and those having cyclothymic disorder. Bipolar patients scored below 8 on the chronic anxiety (CA) scale and tended to be below 7 on the impulsivity (I) scale. Persons

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diagnosed as cyclothymic disorder (CD) showed CA scores of 8 or above and I scores of 7 or above. Patients ultimately responding to tricyclic antidepressants had CA scores of 8 or above and I scores below 7 at intake. These data were based on 22 patients who finished six months of medication and who showed definite improvement.

Several investigators[4,6] have used portions of the Minnesota Multiphasic Personality Inventory to predict medication response. However, when drug response is used as a criterion, those patients who have discontinued medication because of trouble-some side effects are eliminated from the sample. For example, many bipolar patients are more comfortable on a combination of tricyclics and phenothiazines such as Triavil,® than on lithium. These patients would be eliminated from a study based on drug response. The decision as to which medication, if any, to use must go hand in hand with a diagnosis.

The first question, then, is whether the scales on the CA and I scores of the KDS-3A which seemed to characterize the several subtypes of affective disorder when drug response was used as a criterion, are correlated with clinical diagnoses at intake using all patients meriting a particular diagnosis.

The second question relates to the proportion of each subtype of affective disorder which is found in a community mental health outpatient population. A previous study[7] suggested that certain types of affective disorder may be more likely to be associated with welfare dependence. It would be of interest to see whether or not there is an association of any specific type with welfare dependence.

The classification of affective disorders has been recently undergoing revision. The DSM II (Diagnostic Statistical Manual of Mental Disorders) divided depression into endogenous and neurotic with subcategories of each. The DSM III as designed by Spitzer[8] divides affective disorder into intermittent and episodic depressive disorders. Episodic depressive disorders include unipolar and bipolar disorders. Unipolar disorders are divided into major episodic, minor episodic, and unipolar II (patients who have bipolar relatives). Bipolar disorders include bipolar I, bipolar II, and cyclothymic disorder patients.

Table 1. Questions from the KDS-3A Indicating Chronic Anxiety with Assigned Weights

Question	Weight
Do your muscles tighten up when you become anxious?	3
Do you get anxious when you have to ask someone for a favor?	3
Do you get anxious when you meet new people or go to a new place?	3
Do you often get a headache when you feel tense?	2
Do you feel bad for a long time when someone criticizes you?	2
Do you often worry that something bad is going to happen?	1
	14

Table 2. Questions from the KDS-3A Indicating Impulsivity with Assigned Weights

Question	Weight
Do you like being in the midst of excitement?	3
Do you like making quick decisions?	3
Do you tend to lose your temper when you don't get your way?	3
Do you get into fights with people you love?	2
Are you often concerned that somehow you are going to lose control and hurt yourself or somebody else?	2
Do you usually try to be the center of attention or the life of the party?	1
Do you get bored with almost everything you do?	1
	15

Table 3. Items Reported by Kupfer to Separate Unipolar L from Unipolar T

11. Do you stop and think before doing the smallest thing?
14. Do you often get a headache when you feel tense?
20. Do you become easily enthusiastic and just as easily disappointed about people?
28. Can you easily be cheered up even when you get very upset?
31. Do you often think about things that happened when you were a child?
38. When something upsets you, do you eat more, less, or the same?

The category of unipolar II was suggested by Fieve[9] as a way of identifying patients most likely to develop Bipolar affective disorder.

Spitzer's classification lists cyclothymic personality which is characterized by mood swings. Akiskal[10] made a detailed study in which he demonstrated that persons who have not only mood swings but also 'behavioral manifestations of a biphasic nature' have a family history similar to that of bipolar patients. He labeled this cyclothymic disorder as opposed to cyclothymic personality in which mood swings are described without the behavioral manifestations. It is differentiated from sociopathy and hysteria by the ego dystonic features, ie, patients experience a good deal of guilt over their behavior. He emphasized that patients suffering from cyclothymic disorder usually manifest mixed states and that individual patients will not show all of the characteristic behaviors. They often avoid school or work and are sexually promiscuous. Explosive aggressive outbursts may be followed by guilty rumination. Their lives appear to be a series of unfortunate circumstances which may be blamed on social problems or misdiagnosed as character disorder. Since it is generally accepted that medical intervention is required as part of the treatment of affective disorder, accurate diagnosis of cyclothymic disorder is of utmost importance.

Procedure

The subjects in this study were 158 admissions to the Farley Community Mental Health Clinic during the interval from July 1977 to December 1978, who received the diagnosis of intermittent depression, episodic affective disorder, or cyclothymic disorder as part of the routine workup. Subjects were between the ages of 18 and 60. Social Classes 1,2 and 3 comprised 17.1 per cent of the sample; 43 per cent were in Class 4; and 39 per cent in Class 5. Males comprised 32 per cent of the sample; females 68 per cent. Patients were seen by both an intake worker and a psychiatrist, each of whom spent an hour evaluating the diagnosis. Diagnosis was made after a consensus was reached using the criteria described by Spitzer for each category. Unipolar patients having bipolar relatives (unipolar II) were grouped separately as suggested by Fieve. The criteria for cyclothymic disorder were those described by Akiskal. These criteria are detailed below. Patients filled out the KDS-3A personality inventory as part of the evaluation process. Diagnosis was made without reference to the scores on the inventory.

Table 4. Characterization of Diagnostic Groups

Intermittent Depressive Disorder	12 females, 7 males, ages 19-35
Major Episodic Disorder	40 females, 10 males, ages 20-64
Minor Episodic Disorder	8 females, 4 males, ages 21-35
Unipolar II	9 females, 3 males, ages 20-35
Bipolar Affective Disorder I	3 females, 5 males, ages 19-37
Bipolar Affective Disorder II	15 females, 4 males, ages 15-36
Cyclothymic Disorder	15 females, 16 males, ages 16-35

The diagnostic groups were characterized as shown in Table 4.

For the diagnosis of intermittent depression, depressed mood for at least two years is required, possibly with periods of normal mood for less than two months but with sufficient severity to have impaired social functioning, to have resulted in the prescription of medication, or both.

A diagnosis of major depressive disorder was made if at least four of the first eight symptoms listed below were present. Depressed episodes must have been of a minimum of one week in duration, separated by periods of normal mood of at least two months duration. Help must have been sought or the person must have acted differently. Minor depressive disorder was diagnosed if two of the following 16 symptoms were present: 1. poor appetite, weight loss, or increased appetite, weight gain; 2. lessened or increased sleep; 3. loss of energy, fatigue; 4. loss of interest in usual activities or sex; 5. feelings of guilt or worthlessness; 6. trouble concentrating or making decisions; 7. thinking about death or a suicide attempt; 8. being unable to sit still or feeling slowed down; 9. crying; 10. thinking about things with a pessimistic outlook; 11. brooding about unpleasant things that happen; 12. feelings of inadequacy; 13. feelings of resentment, crying; 14. the need for reassurance or help from someone; 15. feeling sorry for oneself; and 16. physical complaints with no physical basis.

The criteria for inclusion in unipolar II are those of major episodic disorder in patients who have a bipolar relative.

A manic episode is characterized by Spitzer as consisting of a period of at least one week when the predominant mood was elevated or irritable and at least two of the following symptoms were present: 1.

more active than usual, 2. more talkative than usual, 3. thoughts were racing, conversation difficult to follow, 4. felt self to be very important, 5. needed less sleep, 6. trouble concentrating because attention kept jumping, and 7. did foolish things, got into trouble.

Manic symptoms must have been of sufficient severity that meaningful conversation was impossible or the person was hospitalized. Hypomanic episodes were similar to manic episodes, but of shorter duration. Bipolar illness was further subdivided into a bipolar I syndrome consisting of both a manic episode and a major, minor, or intermittent depressive episode, and a bipolar II syndrome consisting of at least one episode of hypomania and a major, minor, or intermittent depression in the absence of a previous manic episode.

Cyclothymic disorder was diagnosed using the criteria described by Akiskal[10]. To establish a cyclothymic diagnosis, four of six of the following symptoms were necessary: 1. irritable periods lasting a few days; 2. explosive aggressive outbursts that were ego-dystonic and often followed by periods of guilty rumination; 3. repeated buying sprees, financial extravagance, or disaster; 4. repeated shifts in line of work, study, interest, or future plans; 5. episodic or unexplained promiscuous behavior or extramarital affairs occuring in an ego-dystonic fashion; and 6. impulsive zeal in joining new movements and cults.

The disorder is of a biphasic nature with symptoms such as: hypersomnia alternating with decreased need for sleep, lack of self confidence alternating with grandiose overconfidence, unevenness of productivity often with unusual self-imposed working hours, periods of mental confusion alternating with sharpened thinking, people seeking alternating with introversion, drug abuse in which stimulants alternate with sedatives or dypsomania.

Results

Comparisons were made of the CA and I scores of intermittent depression, major and minor episodic disorder, unipolar II, bipolar I and II, and cyclothymic disorder using the T test of significance for small samples. First episodes of depressive disorder may be followed by the development of manic or hypomanic symptomatology characteristic of bipolar affective disorder. Since the diagnosis is thus less clear with first episodes of depressive disorder, this group was analyzed separately from the group of major depressive disorders. The scores for men and women did not significantly differ when analyzed separately. The scores on the chronic anxiety (CA) and impulsivity (I) scales can be seen in Table 5 for the diagnostic categories described. The questions which measure chronic anxiety and impulsivity with the weights given to each question are shown in Tables 1 and 2.

Intermittent depressive disorder, which can be distinguished from episodic depressive disorder by

Table 5. Chronic Anxiety (CA) and Impulsivity (I) Scales Scores

Diagnosis	Mean	SD
Intermittent Depressive Disorder		
CA	11.3	2.9
I	5.8	3.2
Major Episodic Disorder		
CA	10.5	3.4
I	6.45	3.2
Minor Episodic Disorder		
CA	8.9	2.2
I	5.25	3.7
Major Episodic First Episode		
CA	10.3	3.8
I	6.0	3.3
Unipolar II		
CA	9.6	2.8
I	7.0	4.4
Bipolar I		
CA	7.5	3.7
I	5.1	3.5
Bipolar II		
CA	10.5	2.9
I	6.3	3.2
Cyclothymic		
CA	10.9	3.6
I	10.25	2.3

its clinical course, did not significantly differ in CA or I scores from the episodic disorders. Among the episodic disorders there were no significant differences between the CA or I means of major episodic, minor episodic, major episodic, first episode, unipolar II (relatives bipolar), or bipolar II.

The mean of the CA scores of the bipolar I group differed significantly from the above groups with a probability of $<.05$. The impulsivity mean did not differ. Thus bipolar I disorder can be distinguished from the major episodic disorders by the CA scale of the KDS-3A. Using one standard deviation as a guide, the lower limit of two-thirds of the patients diagnosed as major episodic and intermittent disorder is between 7 and 8. Although there are two atypical scores among bipolar I patients, it can be said that any patient scoring seven or below on the CA scale should be considered to be probably bipolar.

Bipolar I patients, who are distinguishable from cyclothymic disorder clinically because of the episodic course of the illness, are also distinguishable by scores on the KDS-3A. The mean of the CA scores of the cyclothymic group was significantly higher than that of the bipolar I group at a probability of $<.05$. The impulsivity mean was also higher and differed at a level of .001.

Cyclothymic disorder can be distinguished from the major episodic group by the short interval between mood variations and by the impulsivity mean of the KDS-3A, which is higher. Although the CA means did not differ, the I means differed at the level of .001.

Intermittent depressive disorder, however, can be confused with cyclothymic disorder clinically. The I score on the KDA-3A can help to distinguish these two syndromes. Using one standard deviation as a measure of two-thirds of the scores, the lower limit of I scores among cyclothymic patients and the upper limit among intermittent disorder scores is between 8 and 9. Thus it appears that an I score of 9 or above combined with a CA score of 8 or above should alert the clinician to the probable diagnosis of cyclothymic disorder.

Table 6. Percentages of Various Subtypes with Affective Disorder

Intermittent Depressive Disorder	12.5%
Major Episodic Disorder	33.3%
Minor Episodic Disorder	8 %
Unipolar II	8 %
Bipolar Affective Disorder I	5.2%
Bipolar Affective Disorder II	12.5%
Cyclothymic Disorder	20.5%

Kupfer found that unipolar patients who had responded to lithium had a family history similar to bipolar patients. He found that certain items seemed to differentiate the lithium responsive unipolar patients. These items are shown in Table 4. The diagnostic groups which might be expected to be differentiated from the major episodic groups by these items are bipolar II and unipolar II.

Our data indicated that certain items separated bipolar I from the unipolar groups. Item 11 significantly (.05) differentiated bipolar I from bipolar II in which the response was more likely to be positive. It did not differentiate bipolar II from major episodic subjects or from unipolar II. Item 28 likewise separated bipolar I from bipolar II at a level of probability of .02, and from major episodic subjects at the level of .08, with the bipolar I responses positive.

However, in our data only two items seem to separate the groups which would be expected to have a genotype of bipolar disorder, namely bipolar II and unipolar II from major episodic disorder. There was a trend (probability of .08) for bipolar II patients to respond positively to the question regarding eating when under tension, while most patients having major episodic depressions responded negatively. Item 14, which indicated a tendency to have headaches under tension, separated unipolar II subjects from those having major episodic disorder, who tended to respond positively to this question (probability of .02).

Using the above criteria, the percentages of the various subtypes of those persons in a community mental health clinic population who have affective disorder are shown in Table 6.

Since a previous study[7] had suggested that a particular kind of affective disorder might show an increased likelihood of association with welfare dependence, a correlation was made for each subtype using the chi square test for significance. Only cyclothymic disorder showed a significant (.03) correlation with welfare dependence. Whether or not this could be replicated in other Community Mental Health Clinic population samples requires further investigation.

Discussion

We found that the choice of words in this test can be difficult for some patients in the Community Mental Health Clinic population. For example, many do not know the meaning of the word

'anxious'. A modification would be desirable which would make the wording simpler and more comprehensible. However, in spite of this problem, these data indicate that the KDS-3A can serve as a guide in the differential diagnosis of major episodic disorder, intermittent depressive disorder, bipolar disorder, and cyclothymic disorder.

Major episodic disorder differs from minor episodic disorder only in severity. Patients with these disorders tend to be chronically anxious people even between episodes of depression. This is reflected in the high CA score in this self report test. The low I score reflects the even functioning which is seen in spite of this anxiety. Patients with intermittent depressive disorder are chronically depressed as well as anxious. They do not have intervals as long as 2 months when they are free of depression. However, their discomfort does not characteristically prevent them from continuing their usual routine. This even performance is reflected in the low I score.

Unipolar II patients (relative bipolar) cannot be differentiated clinically or by the CA or I scores. However, the highly significant difference in the tendency not to respond to tension with a headache is interesting. This item seems to reflect an absence of chronic anxiety among these patients even though the total CA score was not different from other major episodic groups.

It is possible that some of the diagnoses of bipolar II which were based on patient report of hypomanic episodes were in error. This may account for the fact that the response to the question of eating more when under tension did not quite reach statistical significance. However, the data are supportive of Kupfer's finding that persons who respond positively to this question are probably bipolar.

Bipolar patients have been noted to be gregarious, energetic people when not ill. The lower scores on CA scales even at intake, when symptoms are present, reflects the absence of chronic worry, even when it may be appropriate. The impulsivity characteristic of a manic attack is not present during the depressed or normal phase, allowing for long periods of even functioning. However, when the interval between hypomania and depression is negligible, as in cyclothymic disorder, the impulsivity score is high and serves to help identify this disorder. It is interesting that these are the only two groups in which there are approximately equal numbers of men and women.

Over 50 per cent of affective disorders in a Community Mental Health Clinic population are unipolar depressions. Among the remaining subtypes which are thought to be variants of bipolar disorder, cyclothymic disorder represents the largest group. It is surprising that as much as 20 per cent of affective disorders in this population are cyclothymic. It is possible that earlier characterizations of lower class patients as likely to abandon therapy are related to the frequent diagnosis of cyclothymic disorder with its characteristic impulsiveness. The frequent changes in work or study common to this diagnosis may serve to prevent the accumulation of savings or fringe benefits and result in an increased likelihood of being on welfare. Sexual impulsivity resulting in ill-timed pregnancies could have the same effect.

Treatment available in Community Mental Health Clinics has been influenced by the common supposition that 'lower class' patients are not capable of dealing with psychodynamic concepts but instead want the immediate gratification of medication. These data suggest that this tendency has nothing to do with social class per se but rather with the proportion of cyclothymic disorder among patients suffering from affective disorder.

Various authors have described brief psychotherapies which are either dynamically or behaviorally oriented to be used with intermittent chronic depression. Group psychotherapy is frequently used for character disorders or problems of marital maladjustment in which depression is a clinical feature. It is entirely possible that psychotherapy without medication is the treatment of choice for this kind of depression when primary affective disorder is screened out. However, it is generally accepted that medical intervention is required as part of the treatment of primary affective disorder, unipolar or bipolar. Cyclothymic disorder is a variant of bipolar disorder that can be easily misdiagnosed. Such persons are often classified as alcoholic or hysteric and thus directed toward non-medical regimes. Alcoholics Anonymous (AA) and drug abuse programs emphasize abstinence from all medication. However, patients whose drug or alcohol abuse is part of the syndrome of cyclothymic disorder may derive greater benefit from both psychological and pharmacological support.

Conclusions

The KDS-3A has been found to be an extremely useful guide to diagnostic and treatment decisions. The CA and I scores taken together as well as responses to specific questions can serve to help differentiate bipolar groups from major and minor episodic and chronic depression. While it is important that depressed patients who do not suffer from primary affective disorder including

cyclothymic disorder be given the opportunity to learn to handle life problems without unnecessary medication, it is equally important to diagnose these disorders accurately and to give patients an explanation which allows them to understand the importance of medication as a continuing and perhaps permanent way of handling this illness.

Summary

The KDS-3A is a short personality inventory which is easily adapted to use in clinical practice either in a community mental health clinic setting or private practice. It can be a useful guide in diagnosing bipolar disorders which may not be immediately obvious, including cyclothymic disorder which can be clinically confused with hysteria, sociopathy, or character disorder. Cyclothymic disorder was found to represent a substantial proportion of affective disorders in a community mental health clinic population.

Acknowledgment

The author wishes to acknowledge Professor Kirby Dwight for his help in data analysis and Dr. Abby Rosenfield for her assistance in preparation of the manuscript.

References

[1]Kupfer DJ, Pickar D, Himmelhoch JM, et al: Are there two types of unipolar depression? Arch Gen Psychiatry 32:866-871, Jul 75.

[2]KDS Systems Inc. New Haven, KDS, 1971.

[3]Wold PN, Dwight K: Subtypes of depression identified by the KDS-3A: A pilot study. Am J Psychiatry 136:1415-1419, Nov 79.

[4]House KM, Martin RL: MMPI delineation of a subgroup of depressed patients refractory to lithium carbonate therapy. Am J Psychiatry 132:644-646, Jun 75.

[5]Steinbook RM, Chapman AB: Lithium responders: An evaluation of psychological test characteristics. Compr Psychiatry 11:524-530, Nov 70.

[6]Donnelly EF, Goodwin FK, Waldman IN, et al: Prediction of antidepressant responses to lithium. Am J Psychiatry 135:552-556, May 78.

[7]Wold, PN, Soled S: The family history of mental illness and welfare dependence. J Clin Psychiatr 39:328-331, Apr 78.

[8]Spitzer RL, Endicott J: NIMH Clinical Research Branch Collaborative Program on Psychobiology of Depression.

[9]Fieve RR: Overview of therapeutic and prophylactic trials with lithium in psychiatric patients, in Gershon S, Shapsin B (eds): Lithium: Its Role in Psychiatric Research and Treatment. New York, Plenum Press, 1973, pp 317-350.

[10]Akiskal HS, Djenderedjian AM, Rosenthal RH, et al: Cyclothymic disorder: Validating criteria for inclusion in the bipolar affective group. Am J Psychiatry 134:1227-1233, Nov 77.

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Cigarette Smoking Among Public School Children in Rhode Island

Study Highlights the Factors Which Encourage the Smoking Habit Among Teenagers

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Few public health problems have received more attention in recent years than lung cancer.[1] Since the link between lung cancer and cigarette smoking is now indisputable,[2,3] lung cancer is largely a preventable disease. Nevertheless, the mortality rate from this disease has risen dramatically since 1950, while mortality from other cancers has remained stable or declined.[4]

Fortunately, the proportion of the adult population who are cigarette smokers has also declined.[5] Millions of adult smokers have quit, and each year a smaller proportion is beginning to smoke.[6]

While teenage boys and young men are following the adult trend of decreasing prevalence, teenage girls and young women are not.[7] The proportion of smokers among the latter increased from two to five per cent between 1965 and 1975. This translates into more than a million additional teenage and young women each year who expose themselves and their children to the various adverse affects of cigarette smoking.

This project has been funded at least in part with federal funds from the United States Department of Health, Education and Welfare under contract number N 1-CN-75215 and by the Rhode Island Department of Health. The contents of this publication are the sole responsibility of the author and do not necessarily reflect the views or policies of either agency.

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In January 1978, Joseph Califano, then DHEW Secretary, outlined a series of initiatives designed to reduce the effects of cigarette smoking. Among other things he said, "the only sure way to stop smoking is not to start. We will, therefore, concentrate many of our efforts on prevention among young people of school age . . .".[8]

Study Design and Methods

The purpose of this paper is to report the extent of the smoking problem among public school children in Rhode Island. The focus is upon the proportion of current cigarette smokers by grade and sex.

The data were gathered in conjunction with the School-Based Smoking Project of the Rhode Island Department of Health's Cancer Control Program (RICCP). This model project, developed and conducted through the joint efforts of the Interagency Council on Smoking and the American Cancer Society (Rhode Island Division), is attempting to "reduce by ten per cent per year the proportion of students smoking cigarettes in three target school systems."[9] The three "target" districts were selected, in part, because they represent urban, suburban, and rural communities in Rhode Island and because of a prevailing atmosphere in each area which was conducive to the development of a model program.

Three comparison districts were designated to provide a basis for interpreting the significance of change in smoking prevalence over time. To accomplish this, the urban district was merely split into two parts — one (treatment) consisting of schools in which RICCP activities would be vigorously applied, and the other (comparison) of

schools in which such activities would not be applied. Separate suburban and rural comparison districts were chosen. Since the purpose of this report is to describe the extent of cigarette smoking, all school districts will be examined without treatment or comparison distinctions.

The study design provided for the administration of a brief, anonymous questionnaire to a sample of sixth, eighth, tenth, and twelfth graders in each of the school districts. The questionnaires were administered by members of the research team between December 1978 and April 1979. An effort was made to minimize the biases introduced by the variation in data collection methodology; however, the sampling frame was not rigorous, and a random sample may not have been achieved. In all, 2651 public school children were surveyed, accounting for 1.8 per cent of *all* Rhode Island public school enrollees and 7 per cent of those enrolled in sampled districts (all grades).[10]

Smoking Behavior of Rhode Island Public School Students

Smoking prevalence. Fourteen per cent of male respondents in the four grades currently smoke cigarettes compared to 21 per cent of the females. (Table 1). Conversely, over 38 per cent of males reported having "never smoked", whereas only 32 per cent of females gave this answer. The proportion of cigarette smokers increases significantly with grade level from 2.7 per cent among sixth graders to 28.9 per cent among twelfth graders. With the exception of the sixth grade, females consistently smoke in significantly greater proportions than males of the same grade level.

Table 1. Per cent of Current, Regular Cigaret Smokers Among Public School Children in Fi Rhode Island School Districts by Grade and Se (1975) (N = 2586)

SEX	GRADE				TOTA
	6	8	10	12	
Male	3.5	11.4	18.7	24.3	13.9
Female	1.9	23.9	24.3	33.3	21.0
Both Sexes	2.7	18.1	21.6	28.9	17.6

The smoking behavior of all respondents roughly equivalent when controlled for grade (age) and sex. Therefore, the analysis will proce without distinguishing between urban, suburba or rural districts.

Comparison with United States data. A nation survey in 1974 found that 15.3 per cent of femal (age 12-18) were current, regular cigaret smokers.[11] This represented a substantial increase i

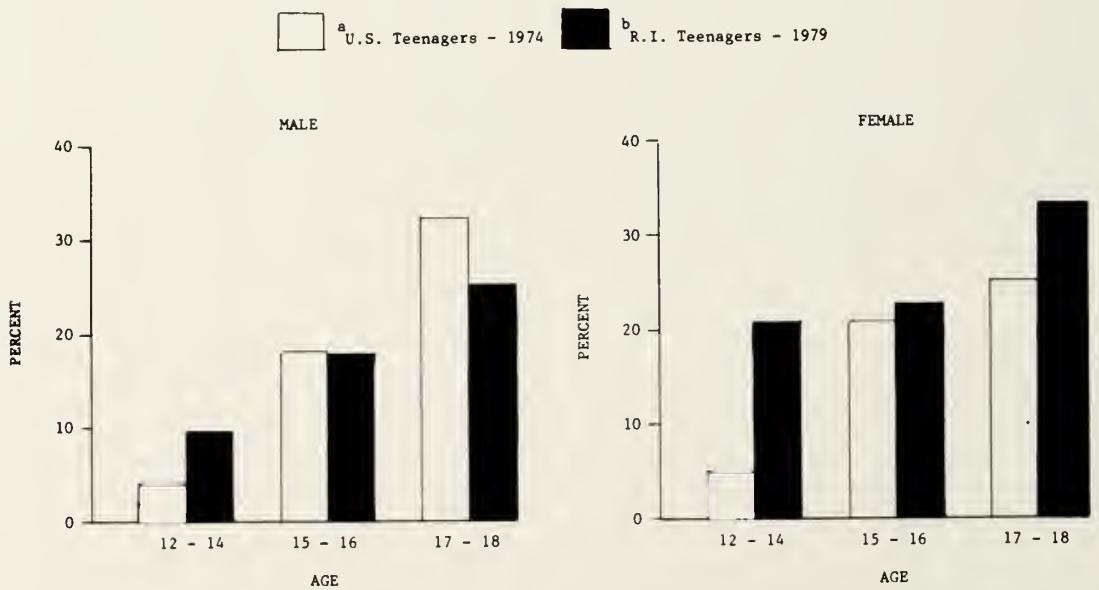

Figure 1 - Percent of teenagers who are current cigarette smokers in United States (1974) and Rhode Island (1979) by age and sex.

a Teenage Smoking, USDHEW Publication No. (NIH) 76-931.

b School Smoking Survey, Rhode Island Cancer Control Program Evaluation Team , 1979.

the proportion of female teenagers who smoked compared to a 1969 survey. The proportion of teenage male smokers hovered around 15 per cent over the same period.

Comparison of data from the RICCP School Smoking Survey and the 1974 national survey by age and sex demonstrates that Rhode Island teenage females are smoking in substantially greater proportions than their national counterparts (Fig. 1). This is especially true between the ages of 12 and 14 where 21 per cent of local female respondents are current cigarette smokers compared to 5 per cent of national respondents. Male Rhode Island respondents (age 12-14) smoke in greater proportions than similarly aged US respondents, but by ages 17-18, local males fall below the national rates.

Adults in Rhode Island were, as recently as 1975, also smoking in greater proportions (39 per cent) than were those in the nation as a whole (34 per cent).[3] However there are signs that the prevalence of cigarette smoking among Rhode Island adults is on the decline.

These comparisons underscore the observations made elsewhere that while the proportion of all adults and teenage males who smoke is declining, cigarette smoking among young women and teenage females is on the increase.[7,11] Since the *risk* of lung cancer due to smoking has been shown to be equivalent among males and females[12,3] — not to mention other cardiovascular and pregnancy-related diseases for which risk may be assessed[13] — cigarette smoking continues to pose a serious public health problem for the schools and the community at large.

Number of years since smoking began. Of the 2608 respondents for whom smoking behavior data were complete (45 cases had missing data), 456 (17.5 per cent) reported that they were current cigarette smokers. These respondents were asked how long ago they had started smoking regularly.

Females start smoking earlier than males. Three-quarters of the eighth grade girls who smoke started one year ago or more compared to less than two-thirds of boys in that grade. By grade 10, 91 per cent of the girls started smoking a year ago or more, whereas in grade 12 only 85 per cent of the boys had been smoking that long. This suggests that, among girls, the passage to grade 9 has an important impact on smoking initiation, while among boys grade 11 has more effect. Since boys and girls are still maturing during these times, there may be a connection (probably social rather than biological) between pubescence and smoking initiation which bears further investigation.

Amount smoked. Respondents reported smoking from one to over five hundred cigarettes *per week* (mean = 60, median = 40). This transposes into a range of less than one cigarette to more than three packs per day — although only 60 smokers (11 per cent) claimed to smoke one pack or more per day. Whereas a larger proportion of males (25 per cent) than females (12 per cent) smoke ten or more cigarettes per day in the eighth grade, the two are nearly equivalent in the tenth grade (32 per cent and 35 per cent) and twelfth grade (55 per cent and 51 per cent), respectively.

These data, when re-categorized by age rather than grade, contrast markedly with the 1974 national survey of teenage smoking (Table 2).

Table 2. Per cent of Smokers Who Smoke Ten or More Cigarettes Per Day, US[a] and RI[b] Teenage Smokers, By Age and Sex.

		MALES AGE			FEMALES AGE		
		12-14	15-16	17-18	12-14	15-16	17-18
10 Or More Cigarettes Per Day	U.S.	52.6	69.0	80.1	26.1	59.7	72.7
	R.I.	17.9	36.0	54.9	11.7	35.2	51.5

[a] *Teenage Smoking*, USDHEW, 1974.

[b] RICCP School Smoking Survey, Evaluation Team, 1979.

Substantially fewer Rhode Island teenagers smoke ten or more cigarettes per day compared to their national counterparts. This is equally true for females, signifying that, while a larger proportion of Rhode Island teenage females are exposed to cigarette smoking than obtains nationally, they are apparently receiving a smaller dose. This observation may signal an opportunity to conduct successful cessation programs, since smoking dosage tends to increase with habituation and those least habituated are the easiest to reform.

Correlates of Smoking Behavior

Several characteristics of individuals and their social environment have been shown in nationwide surveys to be significantly related to cigarette smoking.[1,5,6] Among teenagers, the more significant of these include: socioeconomic status, scholastic achievement, world experience, and the smoking behavior of associates (family and friends).[7,11] Data from this survey were analyzed to determine if any of these variables are related to the proportion of Rhode Island school children who smoke.

Ethnic identification. Respondents were asked if they thought of themselves as belonging to any one

of five ethnic groups (Blacks, French, Oriental, Portuguese, or Spanish American) which have been designated "target" minorities by RICCP.[9] Thirty-two per cent (N = 860) of the respondents answered affirmatively.

Overall, minority group respondents were no more likely to be cigarette smokers (17.8 per cent) than other respondents (17.3 per cent). When the respondents were categorized by sex, a significantly greater proportion of male minority group respondents smoked (17.1 per cent) than non-minority group respondents (12.4 per cent). There were no significant differences among females.

Parents' education. Almost 20 per cent of the respondents did not know the extent of their parents' education. Those who answered were significantly *more* likely to be current smokers if both parents were high school graduates or less (22.6 per cent) than if at least one parent had *some* college education (15.9 per cent). When controlled for sex of respondent, the relationship between parents' education and smoking among school children persisted for both females (28.3 per cent and 18.1 per cent) and males (16.6 per cent and 13.5 per cent) — although the tendency among males was not as strong.

Family smoking patterns. Whether or not other family members smoke significantly affects smoking behavior among the students surveyed regardless of sex. Fifty-three per cent of all students reported that their father smokes, 45 per cent that their mother smokes, 26 per cent that both smoke, and 31 per cent that neither smokes. Respondents, overall, were one-and-a-half times more likely to smoke if *either* parent smoked (21.2 per cent) than if neither smoked (14.2 per cent). The effect was equally strong for males (24.9 per cent and 17.6 per cent) and females (17.2 per cent and 10.8 per cent).

Similarly, 1179 respondents (44 per cent) reported having no older brothers and sisters. Of those that had older siblings, 40 per cent said that *none* of them smoke, while 60 per cent said that *at least one* of them smokes. Respondents having older siblings who smoke were themselves more than *three times* more likely to smoke (29.0 per cent) than those having no older siblings who smoke (8.2 per cent). Results are significant for both males and females, although the relationship is strongest among males.

Smoking behavior among closest friends. Subjects were asked how many of their four closest friends (male and female) smoke cigarettes. Thirty per cent reported having no close friends who smoke while the remainder had at least one friend that does. The effects of reported smoking among friends upon the respondent's own smoking behavior are noteworthy. *Subjects are from twenty-three to nearly thirty times more likely to say that they smoke if they have friends who smoke (26.7 per cent) than if they do not (1.0 per cent).* This relationship persists for both males and females, although it is slightly stronger for females. It is, of course, impossible to determine from the data whether association with a group of friends who smoke causes smoking or whether smokers merely tend to associate with other smokers. Probably both are true. For the purpose of this article it is important only to observe that teenage smokers are immersed in a smoking environment which adds to the symbolic content of their behavior and makes change on an individual level more difficult.

Job experience other than at home. Three-fourths of all respondents (N = 1961) reported that they have had a job for pay other than at home. This represents 80 per cent of male and 70 per cent of female respondents.

Significant differences obtained when the proportion of smokers among those reporting an outside job experience and those reporting no such experience are compared. Twenty per cent of those who had worked outside the home are cigarette smokers compared to less than ten percent of those who had not worked outside the home. The same doubling of the proportion of smokers applies to males and females when analyzed separately.

Grades in school. When asked about their grades in school, nearly half of the students reported that they earned mostly As and Bs. Only 11 per cent admitted that Cs and below were their usual grades. As a result, respondents were separated into groups including those reporting As and Bs only (47.5 per cent) and those reporting all other grades (52.5 per cent).

The proportions of smokers in the two groups were compared. Of those earning the highest grades, 11 per cent were regular cigarette smokers, compared to 23 per cent of those earning lower grades. The difference between the two groups is significant and persists when controlled for sex of the respondents.

Summary and Conclusions

This report focuses on the proportion of current, regular cigarette smokers among public school students in five Rhode Island school districts. An anonymous questionnaire was completed by 2651 subjects in the sixth, eighth, tenth, and twelfth grades. Fourteen per cent of male students and 21

per cent of female students responding currently smoke cigarettes. Female respondents smoke significantly more than male respondents in the same grade.

Female school children in Rhode Island also are smoking in greater proportions (21 per cent) than their national counterparts (15 per cent), but both female and male Rhode Island school children are smoking less heavily. Local teenage females who smoke also begin earlier than local males who smoke.

Sex of respondent, family smoking pattern, smoking among friends, job experience outside the home, and grades in school were all significantly related to cigarette smoking prevalence. Significantly more target minority group males smoke cigarettes (17 per cent) than do other males (12.4 per cent) and fewer respondents whose parents went beyond high school (15.9 per cent) smoke cigarettes than those whose parents did not smoke (22.6 per cent). The latter relationship was significant for females but not for males.

The data on cigarette smoking among public school children in Rhode Island reflect the national situation. Although substantially larger proportions of local respondents (both male and female) report that they are regular cigarette smokers than were found nationally, the effects of grade (or age), family smoking patterns, and other correlates of teenage smoking behavior are consistent. The magnitude of these relationships, however, is compelling. The presence of a smoking parent can increase by 50 per cent the likelihood that a child will smoke. An older sibling who smokes will triple or quadruple that likelihood. Children who have friends who smoke are themselves *many times* more likely to smoke than children having no friends who smoke.

These observations confirm the belief that regular cigarette smoking (or at least the initiation of smoking) among school children is not merely an individual psychological phenomenon. It is markedly affected by the related behavior of associates and by other achievements, opportunities, and life experiences. Consequently, smoking among public school children cannot be reduced simply by educating the individual. We must address the same combination of personal and environmental forces which encourages the initiation of smoking, supports the new smoker during the early period of respiratory discomfort, and maintains his behavior until physical and psychological dependence takes over. The RICCP School-Based Smoking Prevention Project focuses on the knowledge, attitudes, and behavior of teachers, school officials, family members, and other students in addition to the individual. Such approaches possess greater potential for having a significant impact upon the relationships documented in this report, than do those directed solely at the individual.

References

[1]Smoking and Health: A Report of the Surgeon General. US Department of Health, Education and Welfare, Public Health Service, Office on Smoking and Health, 1979.

[2]Kakvan M, Greenberg SD: Cigarette smoking and cancer of the lung: a review. RI Med J 60:588-591, 606, Dec 77.

[3]Marshall RJ: Smoking in Rhode Island. RI Med J 62:215-224, Jun 79.

[4]American Cancer Society: Cancer Facts and Figures. New York, American Cancer Society, 1979.

[5]Adult Use of Tobacco, 1975. National Clearinghouse on Smoking and Health, US Department of Health, Education and Welfare, Public Health Service, 1975.

[6]The Smoking Digest: Progress Report on a Nation Kicking the Habit. US Department of Health Education and Welfare, Public Health Service, National Institutes of Health, 1977.

[7]American Cancer Society: Smoking Among Teenagers and Young Women. Publication No. 77-1203. US Department of Health, Education and Welfare, 1977.

[8]Focal Points. Bureau of Health Education, US Department of Health, Education and Welfare, Apr 78, pp 1-2.

[9]Management and Evaluation Plan. Cancer Control Program, RI Department of Health, 1977.

[10]Percentages based on data provided by RI Department of Education School District Summary Sheets, Fall 1978.

[11]Teenage Smoking: National Patterns of Cigarette Smoking Ages 12 through 18, in 1972 and 1974. Publication No. 76-931. US Department of Health, Education and Welfare, Public Health Service.

[12]Meigs JW: Epidemic lung cancer in women, editorial. JAMA 238:1055, 5 Sep 77.

[13]Hollinshead WH: The consequences of smoking in pregnancy. RI Med J 62:207-212, Jun 79.

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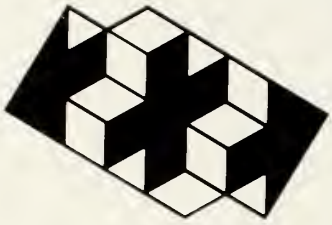

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*Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.[8]

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References
1. Antimicrob. Agents Chemother., *8*:91, 1975
2. Antimicrob. Agents Chemother., *11*:470, 1977
3. Antimicrob. Agents Chemother., *13*:584, 1978
4. Antimicrob. Agents Chemother., *12*:490, 1977
5. Current Chemotherapy (edited by W. Siegenthaler and R. Luthy), II: 880. Washington, D.C.: American Society for Microbiology, 1978
6. Antimicrob. Agents Chemother., *13*:861, 1978
7. Data on file, Eli Lilly and Company
8. Principles and Practice of Infectious Diseases (edited by G.L. Mandell, R.G. Douglas, Jr., and J.E. Bennett), p. 487. New York: John Wiley & Sons, 1979

Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285

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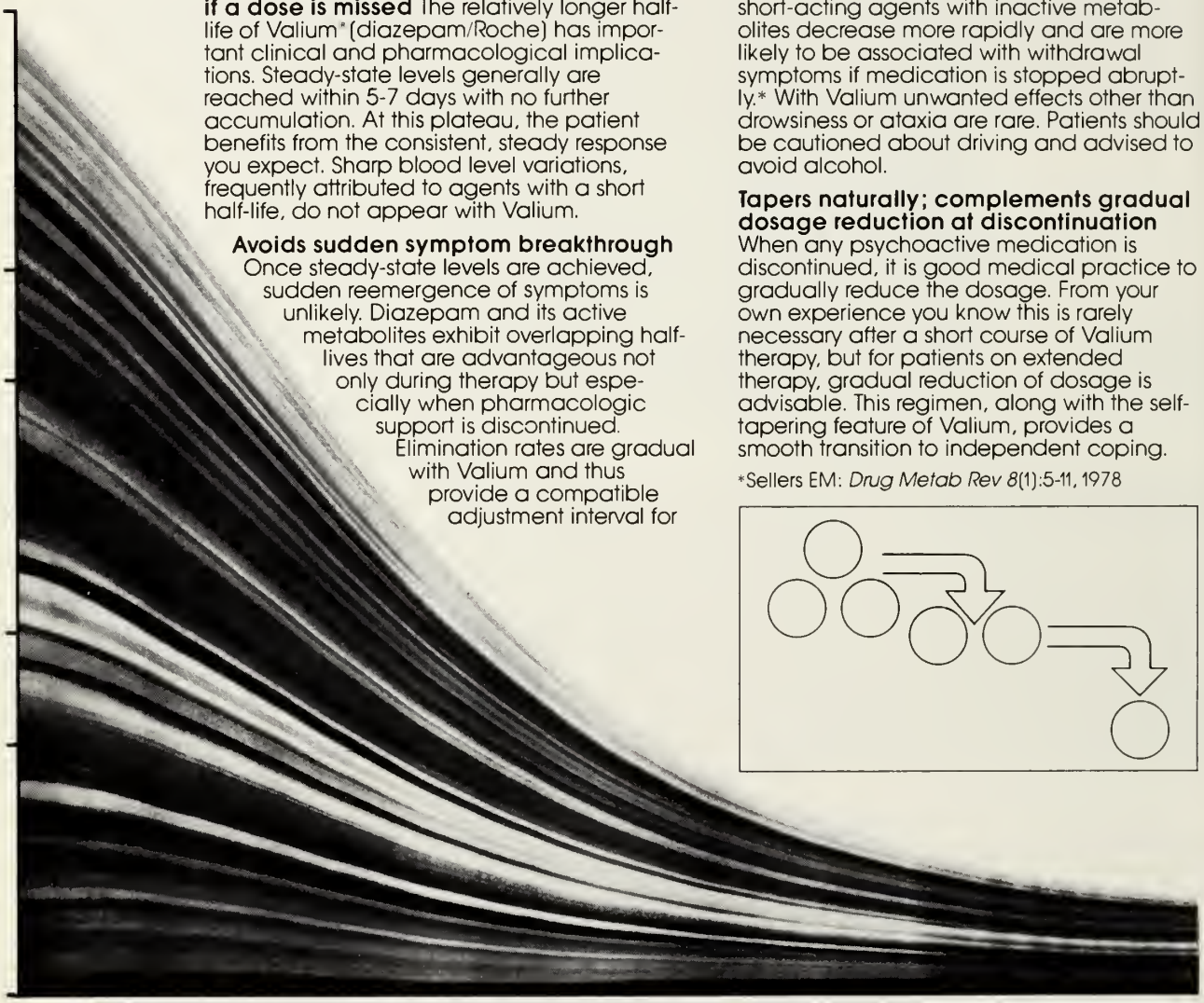

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PTEMBER 26	"USE OF DIURETICS" presented by Owen B. Gilman, MD, Internal Medicine, Kent County Memorial Hospital
TOBER 3	"PAGETS DISEASE" presented by Lewis E. Braverman, MD, Professor of Physiology, University of Massachusetts Medical School
TOBER 10	"THORACIC ANEURYSM" presented by George Cooper, MD, Cardiothoracic Surgeon, Rhode Island Hospital

OCTOBER 17	"AS IT HAPPENED" presented by Edward Asprinio, MD, Department of Family Medicine, Kent County Memorial Ho Agu Suvari, MD, Internal Medicine Department, Kent County Memorial Hospital; and Felix Balasc Cardiologist, Internal Medicine Department, Kent County Memorial Hospital
OCTOBER 24	"ANTICOAGULATION THERAPY IN THE POST MI PATIENT" presented by Sol Sherry, MD, Professor and Chairman, Department of Medicine, Temple University
OCTOBER 31	"THYROID DISEASE" presented by Lewis E. Braverman, MD, Professor of Physiology, University of Massachusetts M School
NOVEMBER 7	"ACUTE RENAL DIALYSIS" presented by Owen B. Gilman, MD, Internist, Kent County Memorial Hospital
NOVEMBER 14	"INFECTION-ANTIBIOTICS" presented by Richard Quintiliani, MD, Associate Professor of Medicine, Hartford Hospital
NOVEMBER 21	"PROPHYLACTIC ANTIBIOTICS — NOSOCOMIAL INFECTIONS" (Lecturer to be announced)
DECEMBER 5	"NUCLEAR MEDICINE UPDATE" presented by Thomas Hunt, MD, Radiologist, Kent County Memorial Hospital
DECEMBER 12	"THE BRAIN AND CAT SCANS" presented by Gillian Newstead, MD, Radiologist, Kent County Memorial Hospital "BRAIN SCANS" presented by Carlos Nieto, MD, Neurologist, Kent County Memorial Hospital "ARTERIOGRAPHY" presented by Vedat Erbug, MD, Radiologist, Kent County Memorial Hospital
DECEMBER 19	"THE ABDOMEN, SPINE, AND CAT SCANS" presented by Gillian Newstead, MD, Radiologist, Kent County Memorial Hospital; and Michael J. F MD, Neurologist, Kent County Memorial Hospital

The Memorial Hospital

INQUIRIES: Ms
722-6000

CARDIOLOGY CONFERENCE	**(1)**	**Tuesdays**	**8:30 am**	**Richardson 1 Lecture Rm**
FAMILY PRACTICE CONFERENCE	**(1)**	**Thursdays**	**Noon**	**Littlefield Conf Rm**
HISTOPATHOLOGY CONFERENCE	**(1)**	**Thursdays (except last of month)**	**2:30 pm**	**Path Museum Conf Rm**
MEDICAL GRAND ROUNDS	**(1)**	**Wednesdays**	**10:00 am**	**Richardson 1 Lecture Rm**
OBSTETRICS CONFERENCE	**(1)**	**Thursdays**	**8:00 am**	**Wood 2 Conf Rm**
ORTHOPAEDIC CONFERENCE	**(1)**	**Thursdays**	**8:00 am**	**Hodgson Conf Rm 550**
PATHOLOGY CONFERENCE (SURGICAL)	**(1)**	**Thursdays**	**2:30 pm**	**Museum Conf Rm**
PATHOLOGY JOURNAL CLUB	**(1)**	**Thursdays (last of month only)**	**2:30 pm**	**Path Museum Conf Rm**
PEDIATRIC CONFERENCE	**(1)**	**Thursdays**	**9:00 am**	**Pediatric Unit**
SURGICAL GRAND ROUNDS	**(1)**	**Thursdays**	**8:00 am**	**Richardson 1 Lecture Rm**
SURGICAL SERVICE CONFERENCE	**(1)**	**Thursdays**	**4:30 pm**	**Richardson 1 Lecture Rm**

The Miriam Hospital

INQUIRIES: Ms.
274-3700

MEDICAL GRAND ROUNDS (Schedule listed below)	**(1)**	**2nd & 4th Thursdays**	**11:00 am**	**Sopkin Aud**

AUGUST 14	"NEW DRUGS IN THE MANAGEMENT OF HYPERTENSION" presented by Aram Chobanian, MD, Professor of Medicine and Chief of the Cardiovascular Institu Boston University School of Medicine
AUGUST 28	"APPROACH TO SALT AND WATER PROBLEMS" presented by Arnold Aberman, MD, Professor of Medicine, University of Toronto; Physician-in-C Mount Sinai Hospital, Toronto

TEMBER 10 "ADRENAL INSUFFICIENCY"
presented by James Melby, MD, Professor of Medicine, Boston University School of Medicine; Chief of the Section of Endocrinology, University Hospital, Boston

TEMBER 18 Title to be announced (Subject: INFECTIOUS DISEASE)
presented by Leon Sabbath, MD, Associate Professor of Medicine, Harvard Medical School and Boston City Hospital

TEMBER 25 Title to be announced
presented by John Edmeads, MD, Associate Professor of Neurology, Sunnybrook Medical Center and University of Toronto

OBER 9 Title to be announced
presented by Daniel G. Wright, MD, Chief of Department of Hematology, Walter Reed Army Institute of Research, Walter Reed Army Medical Center, Washington, DC

OBER 23 "CURRENT STATUS: CT OF THE THORAX"
presented by Robert Pugatch, MD, Associate Professor of Radiology, Tufts University School of Medicine; Staff Radiologist, Boston Veterans Administration Medical Center

EMBER 13 "DISORDERS OF THE PHAGOCYTIC LEUKOCYTES"
presented by Thomas P. Stossel, MD, Associate Professor of Medicine, Harvard Medical School; Chief of Hematology and Medical Oncology, Massachusetts General Hospital.

EMBER 11 Title to be announced
presented by George P. Canellos, MD, Associate Professor of Medicine, Harvard Medical School; Chief of Medicine, Sidney Farber Cancer Institute

UARY 8 "NEUROLOGICAL MANIFESTATIONS OF HEAVY METAL INTOXICATION"
presented by Robert G. Feldman, MD, Professor and Chairman, Department of Neurology, Boston University Medical Center

UARY 22 Title to be announced
presented by Frederic Hoppin, MD, Associate Professor of Medicine and Physiology, Brown University Program in Medicine; Director of the Division of Pulmonary Medicine, The Memorial Hospital

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orton Hospital

nton, Massachusetts

INQUIRIES: Ms. King
617 824-6911 x 383

NTINUING MEDICAL EDUCATION **(2)** **3rd Wednesday** **8:00 am** **Conf Rm**
CTURES
hedule listed below)

PTEMBER 17 "CHRONIC PAIN"
presented by Michael J. Follick, PhD, Assistant Professor of Psychiatry and Human Behavior, Brown University

VEMBER 19 "SPORTS MEDICINE — — Is It Necessary?"
presented by Ernest B. Lowe, Jr., MD, Chief, Sports Medicine Clinic, and Assistant Orthopaedic Surgeon, RI Hospital

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ewport Hospital

INQUIRIES: Mrs. Cranston
846-6400

DICAL EDUCATION LECTURES **(2)** **Tuesdays** **7:30 pm** **Sky Rm**
hedule listed below) **Monthly**

TOBER 28 "WHEN YOUR PATIENT MUST CHANGE HIS LIFESTYLE: PATIENT COMPLIANCE"
presented by George L. Blackburn, MD, Associate Professor of Surgery, Harvard Medical School, Peter Bent Brigham Hospital

CEMBER 2 "MANAGEMENT OF CHOLESTEROL LEVELS: PATIENT COMPLIANCE"
presented by Peter N. Herbert, MD, Associate Professor of Medicine, Brown University

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ewport Naval Regional Medical Center

INQUIRIES: Mrs. Leonard
841-3352

DICAL SPECIAL **(2)** **2nd Wednesday** **3:00 pm** **Command Conf Rm**
hedule listed below) **(Main Building)**

AFF CLINICAL CONFERENCE **(2)** **4th Wednesday** **8:00 pm** **Command Conf Rm**
hedule listed below) **(except**
December 17)

Medical Special Schedule:

OCTOBER 8	"INVESTIGATION OF THE BLEEDING PATIENT" presented by Maurice M. Albala, MD, Associate Professor of Medicine, Brown University
NOVEMBER 12	"SHOCK" presented by Robert W. Hopkins, MD, Professor of Surgery, Brown University
DECEMBER 10	"NUTRITION IN CRITICALLY ILL PATIENTS — TOTAL PARENTERAL NUTRITION" presented by Henry T. Randall, MD, Professor of Surgery, Brown University
JANUARY 14	"POST-TRAUMATIC PULMONARY INSUFFICIENCY" presented by Joseph M. Van de Water, MD, Associate Professor of Surgery, Brown University

Clinical Conference Schedule:

SEPTEMBER 24	"SUICIDE" presented by Psychiatry Service
OCTOBER 22	"GALL BLADDER AND BILE DUCTS" presented by Radiology Service
NOVEMBER 26	"ESTROGEN" presented by OB/GYN Service
DECEMBER 17	Presentation by Pediatric Service to be announced
JANUARY 28	Presentation by Dermatology Service to be announced

Rhode Island Hospital

INQUIRIES: Ms. [illegible]
277[illegible]

ALLERGY DIVISION CONFERENCE	(1)	Thursdays	8:15 am	APC 6th Fl Conf Rm
ANESTHESIA: MORTALITY AND MORBIDITY CONFERENCE	(1)	3rd Wednesday	7:15 am	PR Div Rm 1, 2, 3
CARDIOLOGY:				
CARDIAC CATHETERIZATION CONFERENCE	(2)	Fridays	2:00 pm	APC 155
NOON CONFERENCE	(1)	1st & 3rd Fridays	Noon	APC 155
NON-INVASIVE TESTING CONFERENCE	(1)	Once Monthly		Call 277-5891
THE JOURNAL CLUB	(1)	Mondays	8:00 am	Call 277-5891
GASTROENTEROLOGY:				
G. I. CONFERENCE	(1)	Alternate Mondays	Noon	APC 155
JOURNAL CLUB	(1)	2nd & 4th Tuesdays	Noon	Private Dining Rms
PATHOLOGY CONFERENCE	(1)	Fridays	11:00 am	APC 11th Fl
PATHOPHYSIOLOGY SEMINARS	(1)	Thursdays	8:00 am	APC 155
RADIOLOGY CONFERENCE	(1)	Fridays	Noon	Main X-Ray
ROUNDS	(1)	Tuesdays & Fridays	2:00 pm	Main House
GYNECOLOGY:				
GYNECOLOGY GRAND ROUNDS	(1)	Thursdays	8:00 am	Cafeteria
GYNECOLOGY STAFF CONFERENCE	(1)	First Thursday	8:00 pm	George Aud
GYNECOLOGIC ONCOLOGY CONFERENCE	(1)	Fridays	3:00 pm	Cafeteria
INFECTIOUS DISEASES:				
PEDIATRIC	(1)	First Thursday	Noon	PDR #5
RIH MEDICAL INF DISEASES	(1)	2nd & 4th Tuesdays	Noon	APC 155
MEDICAL ONCOLOGY:				
COMBINED ONC & MNGMT CONFERENCE	(1)	Wednesdays	1:30 pm	George Bldg Lib
MULTIDISCIPLINARY TUMOR CONFERENCE	(1)	3rd Thursday	Noon	George Aud
ONCOLOGY CONFERENCE	(1)	1st & 3rd Tuesdays	Noon	George Bldg Lib

ICINE:				
EDICAL GRAND ROUNDS	(1)	Wednesdays	Noon	George Bldg Aud
BSPECIALTY CONFERENCE	(1)	Monday thru Friday	Noon	APC 155
ROLOGICAL CONFERENCE	(1)	Wednesdays	11:00 am	Conf Rm on 6A
ROSURGERY:				
INICAL ROUNDS	(1)	Mondays	8:00 am	
EURO-PATHOLOGICAL CONFERENCE WITH MARY AMBLER, MD	(1)	Mondays	11:30 am	Dr. Ambler's Off, 2nd Fl
EURO-RADIOLOGICAL CONFERENCE	(1)	Mondays	9:00 am	X-Ray Conf Rm
EUROSURGICAL CLINIC	(1)	Mondays	11:00 am	Neurosurgical Clinic
EUROSURGICAL PLAN CONFERENCE	(1)	Mondays	10:15 am	6B Conf Rm
LEAR MEDICINE CONFERENCE	(1)	Fridays	8:00 am	APC 10th Fl
THALMOLOGY:				
LAUCOMA, RETINA, PATHOLOGY, AND EXTERNAL DISEASE CONFERENCE	(1)	Monthly		Call 277-5509
TAFF CONFERENCE	(1)	3rd Saturday	8:00 am	APC 7th Fl
SITING PROFESSORS		Monthly		Call 277-5509
OLARYNGOLOGY:				
ME CONFERENCE	(1)	Tuesdays	7:00 am	X-Ray Conf Rm, 2nd Fl APC
PC AND STAFF CONFERENCE	(1)	Saturdays	8:00 am	X-Ray Conf Rm, 2nd Fl APC
NT RESIDENT LECTURE SERIES	(1)	Monthly	8:00 am	Conf Rm Hearing & Speech Ctr, 7th Fl APC
OURNAL CLUB	(1)	Monthly	8:00 am	APC 7th Fl
TOLARYNGIC PATHOLOGY CONFERENCE	(1)	Monthly	3:00 pm	APC 11th Fl
EVIEW OF TEACHING FILMS	(1)	Monthly	3:00 pm	APC 7th Fl
EMPORAL BONE LAB	(1)	Monthly	4:00 pm	APC 7th Fl
LEFT PALATE CLINIC	(1)	Monthly	7:30 am	APC 5th Fl
ADIOLOGY CONFERENCE	(1)	Monthly	3:00 pm	X-Ray 2nd Fl
THOLOGY:				
ONE PATHOLOGY CONFERENCE	(1)	1st Wednesday	5:00 pm	Surg Sign-out Rm, 2nd Main Fl Bldg
OMBINED PATH/MED CONFERENCE	(1)	Last Wednesday	Noon	George Aud
I PATHOLOGY CONFERENCE	(1)	Fridays	11:00 am	APC 11th Fl Conf Rm
ROSS ORGAN REVIEW	(1)	Monday thru Thursday	8:15 am	Autopsy Conf Rm, 2nd Fl George Bldg
EUROPATHOLOGY CONFERENCE				
Neurosurgical	(1)	Mondays	11:00 am	Neuropathology Lab 2nd Fl Main Bldg
Neurological	(1)	Once Weekly	Varies	Varies
ATHOLOGY CONFERENCE	(1)	Thursdays	10:45 am	APC 11th Fl Conf Rm Call 277-5151
RENAL PATHOLOGY CONFERENCE	(1)	3rd Monday	1:00 pm	APC 11th Fl Conf Rm
URGICAL MICRO CONFERENCE	(1)	Tuesdays	11:00 am	Surg Sign-out Rm, 2nd Floor Main Bldg
EDNESDAY DIDACTIC CONFERENCE (Topics to be announced)	(1)	Wednesdays Monthly	3:45 pm	APC 11th Fl Conf Rm Call 277-5151
EEKLY AUTOPSY CONFERENCE	(1)	Fridays	1:30 pm	Autopsy Conf Rm, 2nd Fl George Bldg
DIATRICS:				
GRAND ROUNDS	(1½)	Fridays	10:30 am	George Aud
PEDIATRIC CARDIAC CATHETERIZATION CONFERENCE	(1)	Tuesdays	3:00 pm	APC 8th Fl Conf Rm
ASTIC SURGERY CONFERENCE	(1)	Wednesdays	7:30 am	APC 5th Fl Conf Rm

Rhode Island Medical Center

Institute of Mental Health

INQUIRIES: Dr. Bauern 46

DIFFICULT CASE CONFERENCE	Alternate Thursdays	1:00 pm	"A" Bldg Lib
IMH ISSUES	Alternate Thursdays	1:00 pm	"A" Bldg Lib or Admin Bldg Conf Rm
THERAPEUTIC COMMUNITY	Every Friday	9:00 am	IMH Staff DR

General Hospital

INQUIRIES: Dr. I 46

CLINICAL NEUROPATHOLOGICAL CONFERENCE (Schedule listed below)	(1½)	Thursdays	10:30 am	Lab Classroom, Mathias
GERIATRICS AND GERONTOLOGY COURSE (Schedule listed below)	(1½)	Mondays	8:30 am	Lab Classroom, Mathias
MEDICAL GRAND ROUNDS	(1)	Tuesdays Monthly	10:30 am	LP Conf Rm
MEDICAL WARD ROUNDS	(1)	Mon, Wed, Fri	9:30 am	Call 464-3493
PSYCHOGERIATRIC CLINICAL CASE PRESENTATION (Schedule listed below)	(1)	Tuesdays	9:30 am	Hazard Bldg

Clinical Neuropathological Conference Schedule:

SEPTEMBER 18	Title to be announced presented by William McEntee, MD, Associate Professor of Medicine, Brown University; Di Neurology Department, VA Medical Center
OCTOBER 16	To be announced
NOVEMBER 13	Title to be announced presented by Thomas Sabin, MD, Associate Professor of Neurology, Boston University Medical Sh Director, Neurological Unit, Boston Children's Hospital
DECEMBER 18	To be announced

Geriatrics and Gerontology Course Schedule:

SEPTEMBER 15	"ALCOHOLISM IN THE AGED" presented by Alfredo Cassiet, MD, and Oscar Liu, MD
SEPTEMBER 29	"DRUG INTERACTIONS IN THE AGED, AND PRACTICAL PROBLEMS IN THE ADMINISTRATIO DRUGS IN THE AGED" presented by B.B. Motola, MD, and Johannes Virks, MD
OCTOBER 6	"SCHIZOPHRENIA IN THE AGED, AND AGING SCHIZOPHRENICS" presented by Robert Becker, MD, and John Karkalas, MD
OCTOBER 20	"HYPERTENSION IN THE ELDERLY" presented by Edward C. Keene, MD
NOVEMBER 10	"DEATH AND DYING" presented by Samuel Hassid, MD, and Beatriz Lega, MD
NOVEMBER 17	"NUTRITION IN THE AGED" presented by James Bergan, PhD, Department of Food Sciences and Technology, University of Island
NOVEMBER 24	"CONFUSION, FALLING, INCONTINENCE, AND HOMEOSTATIC BREAKDOWN AS FOUR OF THE MONEST PROBLEMS IN OLD AGE" presented by Irving A. Beck, MD, and Marco Calvo, MD
DECEMBER 1	"RHEUMATOLOGIC PROBLEMS UNIQUE TO THE AGED" presented by Peter Himmel, MD, and Philemon Marvell, MD
DECEMBER 15	"ADVANTAGES AND DISADVANTAGES OF PHYSICAL ACTIVITY IN THE AGED" presented by Veronique Susset, MD
JANUARY 12	"SIGNIFICANCE OF FUNCTIONAL AND PSYCHOSOCIAL EVALUATION OF CHRONICALL PATIENTS" presented by Ando Suvari, MD
JANUARY 26	"EXTRA PYRAMIDAL SYNDROMES IN THE AGED" presented by Petro Karavasias, MD

hogeriatric Clinical Case Presentation Schedule:

EMBER 9 presented by Ando Suvari, MD
OBER 14 presented by Jacques Mioni, MD
EMBER 18 presented by Ando Suvari, MD
EMBER 9 presented by Jacques Mioni, MD

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ger Williams General Hospital

INQUIRIES: Ms. Fogarty
456-2034

DIOLOGY:				
RAND ROUNDS	(1)	2nd & 4th Fridays	10:00 am	Greene Lounge
OUSESTAFF CONFERENCE	(1)	1st Monday	12:30 pm	Ctr 2 Conf Rm
IICAL PHARMACOLOGY FERENCE	(1)	3rd Thursday	12:30 pm	Greene Lounge
IICOPATHOLOGIC CONFERENCE :)	(1)	3rd Thursday	11:00 am	Kay Aud
OCRINOLOGY CONFERENCE	(1)	2nd Wednesday	12:30 pm	Greene Lounge
ICS CONFERENCE	(1)	3rd Tuesday	12:30 pm	Kay Aud
OUSESTAFF CONFERENCE edule listed below)	(1)	1st Friday	12:30 pm	Ctr 2 Conf Rm
IATOLOGY/ONCOLOGY HOUSESTAFF IFERENCE edule listed below)	(1)	Fridays*	12:30 pm	Ctr 2 Conf Rm
ECTIOUS DISEASE HOUSESTAFF IFERENCE	(1)	1st Tuesday	12:30 pm	Ctr 2 Conf Rm
DICINE:				
RAND ROUNDS chedule listed below)	(1)	Tuesdays (except September 9)	11:00 am	Kay Aud
HYSICIAN-IN-CHIEF'S ROUNDS	(1)	Thursdays (except 3rd)	11:00 am	Kay Aud
HROLOGY HOUSESTAFF IFERENCE	(1)	Tuesday Monthly	12:30 pm	Ctr 2 Conf Rm
IROLOGY HOUSESTAFF IFERENCE edule listed below)	(1)	1st Wednesday	12:30 pm	Ctr 2 Conf Rm
IATRIC TEACHING ROUNDS edule listed below)	(1½)	Fridays	10:30 am	Kay Aud
MARY CARE CONFERENCE	(1)	1st Wednesday	12:30 pm	Ctr 2 Conf Rm
CHIATRY CONFERENCE	(1)	Fridays Monthly	12:30 pm	Ctr 2 Conf Rm
MONARY HOUSESTAFF IFERENCE	(1)	Mondays Monthly	12:30 pm	Ctr 2 Conf Rm
EUMATOLOGY GRAND ROUNDS	(1½)	Fridays	8:00 am	Dept Med Lib
RGICAL CONFERENCE	(1)	Wednesdays	7:30 am	4th Fl Prior Hall
OLOGY ROUNDS	(1)	Fridays	8:30 am	Path Trailer #2 Conf Rm

ceptions: Mondays, January 18 and April 10

Housestaff Conference Schedule:

PTEMBER 5 "HEPATIC ENCEPHALOPATHY"
presented by Nicholas Califano, MD

TOBER 3 "GASTROINTESTINAL CANCER"
presented by Thomas Flannery, MD

NOVEMBER 7 "DIARRHEA"
presented by Michael Turner, MD

DECEMBER 5 "INFLAMMATORY BOWEL DISEASE"
presented by Herbert Rakatansky, MD

JANUARY 9 "PANCREATIC DISEASE"
presented by Edward Feller, MD

Hematology Oncology Housestaff Conference Schedule:

SEPTEMBER 12 "CONCEPTS OF CANCER TREATMENT AND CLINICAL PHARMACOLOGY"
presented by E. Spremulli, MD

OCTOBER 10 "BREAST CANCER"
presented by F.J. Cummings, MD

NOVEMBER 17 "HODGKIN'S AND NON-HODGKIN'S LYMPHOMA"
presented by C.H. Doolittle, MD

DECEMBER 12 "ACUTE LEUKEMIAS AND MYELOMA"
presented by M.C. Wiemann, MD

JANUARY 16 "LUNG CANCER"
presented by E. Spremulli, MD

Medical Grand Rounds Schedule:

SEPTEMBER 2 "REVERSIBLE ASPECTS OF OBSTRUCTIVE LUNG DISEASE"
presented by John Urbanetti, MD, Chief of Pulmonary Medicine, Yale University

SEPTEMBER 16 "ACUTE AND CHRONIC PAIN"
presented by Allan Kliman, MD, Department of Hematology/Oncology, Massachusetts Rehabilita
Hospital

SEPTEMBER 23 "SYPHILIS UPDATE"
presented by Nicholas Fiumara, MD, Director, Division of Communicable Disease, Commonweal
Massachusetts

SEPTEMBER 30 "CANCER IN INFLAMMATORY BOWEL DISEASE"
presented by Walter R. Thayer, MD, Head, Division of Gastroenterology, Rhode Island Hos
Professor of Medicine, Brown University

OCTOBER 7 "RATIONAL MANAGEMENT OF HYPERTENSIVE EMERGENCIES"
presented by Charles Tift, MD, Director, Boston City Police Department, Hypertension Detection Uni

OCTOBER 14 "MODERN PRINCIPLES IN THE USE OF PROPHYLACTIC ANTIBIOTICS"
presented by Richard Quintiliani, MD, Director, Division of Infectious Diseases, Hartford Hospital

OCTOBER 21 "G-CELL HYPERPLASIA"
presented by Herbert Rakatansky, MD, Clinical Assistant Professor of Medicine, Brown Univeristy

OCTOBER 28 "NEPHROTIC SYNDROME"
presented by Burton David Rose, MD, Director, Division of Nephrology, St. Vincent's Hospital; Assoc
Professor of Medicine and Physiology, University of Massachusetts Medical School

Neurology Housestaff Conference Schedule:

SEPTEMBER 3 "COMA II: DISEASE STATES — STRUCTURAL AND METABOLIC"

OCTOBER 1 "NEUROLOGICAL EMERGENCIES"

NOVEMBER 5 "HEAD TRAUMA"

DECEMBER 3 "STROKE: DIAGNOSIS AND TREATMENT"

JANUARY 7 "NEUROLOGICAL COMPLICATIONS OF CANCER"

Pediatric Teaching Rounds Schedule:

SEPTEMBER 19 "CURRENT ADVANCES IN PEDIATRICS"
presented by Frank A. Oski, MD, Professor and Chairman of Pediatrics, State University Hosp
Upstate Medical Center, New York

DECEMBER 12 "RICKETS"
presented by Constantine S. Anast, MD, Professor of Pediatrics, Harvard Medical School; Se
Associate in Medicine, Boston Children's Hospital Medical Center

JANUARY 16 "GIARDIASIS AND AMEBIASIS, TWO SERIOUS PARASITIC INFECTIONS ENCOUNTERED IN
NORTHEAST"
presented by Michael Katz, MD, Reuben S. Carpentier Professor and Chairman of Pediatrics, Colun
University, College of Physicians and Surgeons; Professor of Public Health (Tropical Medicine); Dire
of Pediatric Service, New York Babies Hospital

.Anne's Hospital

.iver, Massachusetts

INQUIRIES: Mrs. Pelletier
617 674-5741 x 258

ICIANS EDUCATION CONFERENCE (2) Wednesdays 8:30 am Clemence Hall
dule listed below)

EMBER 10 "MATURITY ONSET IN DIABETIC"
presented by Leo Kroll, MD, Joslin Clinic, Boston

EMBER 24 "SURGICAL POST-OP WOUNDS"
presented by Donald Fry, MD

)BER 1 To be announced

)BER 15 "COPD"
presented by John Urbanetti, MD, Pulmonary Division, Yale University School of Medicine

)BER 29 "TOTAL PARENTERAL NUTRITION"
presented by William P. Steffee, MD, Director of Clinical Nutrition Unit, University Hospital; Assistant Professor of Medicine, Boston University School of Medicine

EMBER 5 "TREATMENT OF THE COMPROMISED HOST"
presented by James Pennington, MD, Assistant Professor of Medicine, Peter Bent Brigham Hospital, Harvard Medical School

EMBER 26 "USE AND ABUSE OF AMINOGLYCOSIDES IN SERIOUS GRAM NEGATIVE INFECTIONS"
presented by H. Ram Chowdri, MD

EMBER 3 "ACUTE RESPIRATORY DISTRESS SYNDROME"
presented by Carl Sherter, MD, Chief of Pulmonary Medicine, Yale University

EMBER 10 "ESTROGEN REPLACEMENT THERAPY"
presented by William F. Crowley Jr., MD, Department of Gynecology and Endocrinology, Massachusetts General Hospital

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Joseph Hospital

INQUIRIES: Dr. Mathieu
521-3231

.DREN AND YOUTH SERIES: (1) 2nd Tuesday 8:00 pm Stang Classroom, Providence Unit
edule listed below)

TEMBER 9 "EMERGENCY ROOM MEDICINE: CHILDREN AND YOUTH"
presented by Jorge Alonso, MD; Ernest P. Mennillo, MD; and Dong Suk Lee, MD

OBER 14 "SUICIDE: AN ADOLESCENT PROBLEM"
presented by Stephen A. Feldman, MD, Clinical Assistant Professor of Pediatrics, Brown University

EMBER 11 "DRUG ADDICTION: PSYCHIATRIC IMPLICATIONS IN THE PERINATAL AND NEWBORN"
presented by Barry Garfinkel, MD, Assistant Professor of Psychiatry and Human Behavior, Brown University; Director of Training and Research, Bradley Hospital

EMBER 9 "THE METABOLIC LABORATORY: A PHYSICIAN'S UPDATE"
presented by W. Patrick Zeller, MD, Fellow in Metabology, Rhode Island Hospital

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uth County Hospital

INQUIRIES: 783-3361

)ICAL EDUCATION PROGRAM (2) 1st Friday 10:00 am Bacon House Lib
iedule listed below)

TEMBER 5 "COLITIS; DIFFERENTIAL DIAGNOSIS, TREATMENT AND PROGNOSIS"
presented by Philip Torgan, MD, Clinical Assistant Professor of Medicine, Brown University

TOBER 3 "THE MEDICAL EXAMINER'S OFFICE AND THE HOSPITAL COMMUNITY"
presented by William Q. Sturner, MD, Chief State Medical Examiner; Professor of Pathology and Community Health, Brown University

VEMBER 7 "ACUTE LEUKEMIAS; DIAGNOSIS, TREATMENT AND PROGNOSIS"
presented by Mario G. Baldini, MD, Professor and Chairman, Section of Medicine, Brown University

CEMBER 5 "THEORETICAL AND CLINICAL ASPECTS OF SEXUAL DIFFERENTIATION"
presented by Jay M. Orson, MD, Clinical Associate Professor of Pediatrics, Brown University

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A Medical Center

INQUIRIES: Ms. Adams
273-7100

MC — BROWN UNIVERSITY CO-SPONSORED REGULARLY RECURRING ROUNDS:

CHEST CONFERENCE	(1)	Wednesdays	1:30 pm	VAMC 648
CLINICAL NEUROLOGY	(1)	1st & 4th Mondays	1:00 pm	VAMC 648
CLINICAL NEUROPATHOLOGY	(1)	2nd Monday 3rd Friday	1:00 pm 10:30 am	VAMC 648 5th Fl VAMC
ENDOCRINOLOGY AND METABOLISM	(1)	3rd Monday	1:00 pm	VAMC
GASTROINTESTINAL CONFERENCE	(1)	2nd Tuesday	11:00 am	Radiology Svc
GENITOURINARY CONFERENCE	(1)	3rd Tuesday	3:15 pm	Radiology Svc
G I CONFERENCE	(1)	Mondays	4:00 pm	VAMC 648
GRAND ROUNDS-MEDICAL SERVICE	(1)	Tuesdays	9:00 am	6th Fl VAMC
GRAND ROUNDS-SURGICAL SERVICE	(1)	Fridays	7:30 am	VAMC 648
NEPHROLOGY SEMINAR	(1)	1st & 3rd Tuesdays	1:00 pm	VAMC
NEUROSCIENCES SEMINAR	(1)	3rd Monday	3:30 pm	Rm 2, 5th Fl Aud
TUMOR BOARD	(1)	Mondays	2:30 pm	VAMC
ULTRASOUND-NUCLEAR MEDICINE	(1)	Wednesdays	Noon	6th Fl VAMC
VASCULAR CONFERENCE-SURGICAL SVC	(1)	Wednesdays	2:30 pm	VAMC 648

Women and Infants Hospital

INQUIRIES: Ms. Bal
274-

OB/GYN:				
ENDOCRINE/INFERTILITY CONFERENCE	(1)	Wednesdays (two monthly)	7:45 am	Aud
GRAND ROUNDS	(1)	Wednesdays	9:00 am	Aud
PATHOLOGY CONFERENCES WITH DR. STUART LAUCHLAN	(1)	Wednesdays (two monthly)	7:45 am	Aud
TEAM CHIEFS' TEACHING ROUNDS	(1)	Saturdays	8:00 am	Aud
PERINATAL MANAGEMENT CONFERENCE	(1)	Thursdays	7:45 am	Aud
TUMOR BOARD MEETING	(1)	Tuesdays	7:30 am	Aud

On the 4th Saturday of the month, the Hospital has a guest lecturer at 9:00 am.

Zambarano Memorial Hospital

INQUIRIES: Mrs. Nic
568-2551 x

MONTHLY EDUCATIONAL LECTURES: (Schedule listed below)	(1)	3rd Thursday	10:30 am	Medical Conf Rm

SEPTEMBER 18	"MACROCYTIC ANEMIA" presented by Irving Beck, MD, Consultant in Geriatrics and Medicine
OCTOBER 16	"PNEUMONIAS — ESPECIALLY RELATIONSHIP TO LEGIONNAIRE'S DISEASE" presented by Fredy Roland, MD, Assistant Professor of Medicine, Brown University; Epidemiolo Memorial Hospital
NOVEMBER 20	"TOPICS IN PULMONARY MEDICINE" presented by William Corrao, MD, Assistant Professor of Medicine, Brown University; Director of monary Function Laboratory, Rhode Island Hospital
DECEMBER 18	"HEMATOLOGICAL SUBJECTS" presented by Irving Beck, MD, Consultant in Geriatrics and Medicine

Courses and Symposia

PEMBER 12, 13, and 14

\NCED CARDIAC LIFE SUPPORT COURSE sponsored by RI Affil, American Heart Assn
M: 12th from 7:00-10:00 pm; 13th from 8:00 am-5:00 pm; 14th from 8:00 am-1:00 pm
A E: Fogarty Memorial Hosp, Eddie Dowling Hwy, N Smithfield, RI
E $100 physicians, $55 critical care nurses
EDIT: 12 hours
NTACT: Kenneth Linhares 728-5300

PEMBER 18, 1980 — FEBRUARY 26, 1981

IS INTERVENTION THEORY AND PRACTICE COURSE sponsored by Brown Univ and RI Hosp, Dept of Psychiatry
M: Thursdays at 7:30-9:00 pm
A E: RI Hosp, APC 155
E $210
EDIT: 31.5 hours
NTACT: Alicia Jordan 277-5488

course will consist of 21 sessions of didactic lectures and question and answer periods on the theory and practical cation of crisis intervention techniques (eg, evaluation of depression, suicide and homicidal potential, and rape). rers and their topics will be "Psychopharmaco-therapy in the Crisis Situation; Diagnosis and Management of Acute nic Mental Syndromes in the Crisis Situation" presented by Richard J. Goldberg, MD, Instruc in Psych & Human v, Brown Univ and Assoc Dir, Dept of Psych, RI Hosp; "Brief Psychotherapy" presented by Lee H. Goldstein, DO, Clin tuc of Psych & Human Behav, Brown Univ and Dir, Adult OP Psychiatry, RI Hosp; "Working with Community Agencies risis Management; Diagnosis and Management of Alcohol Syndromes; Systems Issues in Providing Emergency nces—Dealing with Crisis with Patients and Staff; Crisis Therapy of Rape Victims and Battered Spouses" presented by ro Inglese-Bieber, RN, MPH, Instruc of Psych & Human Behav, Brown Univ and Div Dir, Psych Nursing; Dir of Emerg n, RI Hosp; "Management of Crises in Childhood; Management of Crises of Adolescence" presented by Beverly A. es, MD, Asst Prof of Psych & Human Behav, Brown Univ and Director, Child & Family Devel, RI Hosp; "History of Crisis evention and the Theoretical Basis of Crisis Work; History Taking in the Crisis Situation; Diagnosis and Management of nol Syndromes; Evaluation of Homicidal and Suicidal Potential; the Biopsychosocial Model in the Emergency Setting; nosis and Management of Acute Organic Mental Syndromes in the Crisis Situation" presented by Andrew Slaby, MD, of Psych & Human Behav, Brown Univ and Psychiatrist-in-Chief, RI Hosp; "Management and Treatment of Drug Related tance Abuse" presented by Norma Sullivan, RN, MS, Psych Consult Liaison, Nurse Clin Specialist; "Legal Issues in sion of Emergency Care" presented by Laurence R. Tancredi, JD, MD, Assoc Prof of Law & Psych, NYU Law Sch; is and Life Threatening Illness" presented by Robert M. Tull, PhD, Clin Asst Prof, Psych & Human Behav, Brown Univ Director, Sect on Psych & Oncology, RI Hosp; "Engaging the Patient" presented by Stephen R. Wallace, MSW, Chief h Social Worker and Assoc Dir of OP Psych, RI Hosp.

EMBER 26, 27, and 28

RGENCY AND CRITICAL CARE SYMPOSIUM '80 "Management of Medical Emergencies and Trauma" sponsored by n Univ, RI Chap American Coll of Emerg Phys; RI Affil, American Heart Assn
E: 26th from Noon-9:00 pm; 27th from 7:30 am-5:30 pm; 28th from 8:30 am-5:30 pm
CE: Providence Marriott Inn
$150 physicians; $75 house officers, RTs, PAs & nurses; $25 students
DIT: 20 hours (2.1 nurses, 15 EMTs)
TACT: Kenneth Linhares 728-5300

se director is William Kaye, MD, Assoc Prof of Surg (Crit Care Med), Brown Univ; Director, Div of Crit Care Med, Miriam and co-director is Donald Baxter, DO, Clin Faculty, New England Coll of Osteopathic Med; President, RI Chap, Amer Emerg Phys; Director, Emerg Dept, Cranston General Hosp.

at will be case presentations with lectures covering differential diagnosis and general principles of management. owing the didactic presentations, there will be a series of workshops which will emphasize audience participation. e workshops will be devoted to the specific management of the cases presented.

TEMBER 27

RKSHOP ON BASIC AO PRINCIPLES sponsored by Brown Univ and RI Hosp, Dept of Surg
E: 8:30 am - 5:00 pm
CE: RI Hosp
$30

CREDIT: 7 hours
CONTACT: Dr. Deutsch 861-2261

This program is designed to introduce the orthopaedic practitioner to the basic principles of lag screws, tension techniques and compression plates. It will be theoretical and practical with hands on use of the AO equipment with pl bones. Guest lecturer will be Howard Rosen, MD, Assoc Clin Prof of Orthopaedic Surg, Mt Sinai Sch of Med; Atter Orthopaedic Surgeon and Chief, Problem Trauma Service, Hosp for Joint Diseases Orthopaedic Inst. Course limited practitioners.

OCTOBER 9-13

GYNECOLOGIC SURGERY COURSE sponsored by Brown Univ and Women & Infants Hosp
TIME: 9:00 am - 5:00 pm
PLACE: Queen Elizabeth II cruise to Bermuda
FEE: $300
CREDIT: 14 hours
CONTACT: Dr. Nichols 274-1100 x 548

This course is designed to identify, develop and demonstrate skills pertaining to surgical techniques and problems may arise either commonly or unexpectedly in the day's regular surgical activity. Illustrative representative prob oriented case presentations will be provided to initiate each scheduled conference. A particular problem will be identi and appropriate solution developed, alternate solutions discussed, and measures identified that might be taken to pre or reduce the likelihood of future recurrence of the problem. Audience participation is encouraged, with opportunit small group or private discussion with the faculty members. Faculty will be David H. Nichols, MD, Prof and Chmn, Se of Ob/Gyn, Brown Univ; Richard F. Mattingly, MD, Prof and Chmn, Dept of Ob/Gyn, Medical Coll of Wis; and Joh Thompson, MD, Prof and Chmn, Dept of Ob/Gyn, Emory U Sch of Med.

OCTOBER 20 — DECEMBER 22, 1980 (Part II, March 2 — June 1, 1981)

SELECTED TOPICS IN INTERNAL MEDICINE sponsored by Pawtucket Memorial Hosp
TIME: 7:30 - 9:00 pm
PLACE: Richardson Aud
FEE: Call for info
CREDIT: One hour
CONTACT: Dr. Baldini 722-6000 x 2240

The course will cover topics on Endocrinology, General Medicine, Infectious Disease, Internal Medicine in Office Prac Oncology, and Pulmonary Diseases.

OCTOBER 22

SECOND ANNUAL CONFERENCE ON DEAFNESS "Central Auditory Processing Problems, Evaluation and Treatm sponsored by RI Div of Vocational Rehab; RI Hosp, Hearing and Speech Ctr; and Depts of Otolaryng and Ped
TIME: 8:30 am - 5:30 pm
PLACE: George Aud, RI Hosp
FEE: $20 (no charge residents or students)
CREDIT: To be determined
CONTACT: J. Barry Regan 277-5485

OCTOBER 24, 25, and 26

ADVANCED CARDIAC LIFE SUPPORT COURSE sponsored by RI Affiliate, American Heart Assn
TIME: Call for info
PLACE: St. Joseph Hosp, Prov Unit
FEE: Call for info
CREDIT: Call for info
CONTACT: Kenneth Linhares 728-5300

NOVEMBER 1

ANNUAL BRADLEY SYMPOSIUM "The Aggressive Child in School" sponsored by Brown Univ and Bradley Hosp
TIME: 8:30 am - 4:30 pm
PLACE: Ray Aud, Butler Hosp
FEE: $25
CREDIT: 6 hours
CONTACT: R. Hostein 434-3400 x 245

Faculty will include Carl Malmquist, MD, Prof of Law & Psychiatry, Univ of Mich and Pappanikou, PhD, Pro Special Education, U Conn. In addition, there will be six panelists representing psychiatry, psychology, social work, and (attorney and family court justice).

EMBER 1

NAR ON PROSTAGLANDINS sponsored by Brown Univ Comm on Cont Med Educ

M: 8:30 am - 5:00 pm
CE: Barus-Holley 166 on Brown campus
E $35 (includes luncheon)
DIT: 6 hours
TACT: I. Owens 863-3337

colloquium will address the basic fundamentals of the physiology and pathophysiology of prostaglandins and will re selected discussions by experts on the present and future medical and surgical applications of this knowledge. t lecturer will be Peter Ramwell, MD, Prof of Physiology and Biophysics, Georgetown Univ Med Ctr. Brown faculty will de Andrew Blazar, MD, Clin Asst Prof of Ob/Gyn; Angelina Carvalho, MD, Asst Prof of Med (Hematology); Stephen R. an, MD, Assoc Prof of Med (Rheumatology); Patricia A. Rompf, MD, Clin Instruc in Ped; and Barbara R. Stonestreet, MD, Prof of Ped.

EMBER 5

OND ANNUAL NEW ENGLAND CONFERENCE ON ENVIRONMENTAL AND GENETIC FACTORS IN BIRTH DEFECTS sored by Brown Univ, Genetic Counseling Ctrs of RI, RI Dept of Health, RI Sect of ACOG and NAACOG, and Women nfants Hosp

E: 8:00 am - 4:30 pm
CE: Biltmore Plaza Ballroom
$25 Physicians
DIT: 5.5 hours
TACT: Isabel Baldyga 274-1100 x 324

st lecturers will be Donald P. Goldstein, MD, Asst Clin Prof Ob/Gyn, Harvard Univ; Director, Trophoblastic Disease Ctr, on Hosp for Women; Chief, Ped Gyn, Boston Children's Hosp; Albert P. Scheiner, MD, Dept Ped, U Mass Sch of Med; ard W. Webster, PhD, Prof of Radiology, Harvard Med Sch; Director, Radiological Science Div, Mass General Hosp; ner B. Yaffe, MD, U Penn Sch of Med; and Johan Zwann, MD, Harvard Univ Sch of Med, Mass Eye & Ear Infirmary.

EMBER 12

ENTEENTH ANNUAL MAURICE N. KAY PEDIATRIC SYMPOSIUM "Current Advances in Pediatrics" sponsored by Dept ed, Roger Williams Gen Hosp

E: 9:30 am - 5:00 pm
CE: Kay Aud, Roger Williams Gen Hosp
$25 physicians, $5 residents (includes luncheon)
DIT: 4.5 hours
TACT: Carol Holscher 456-2350

st lecturers and topics will include "Management Issues in Chronic Disease during Adolescence" presented by aael Cohen, MD, Prof & Deputy Chmn, Dept of Ped, Albert Einstein Coll of Med; Director, Div Adol Med, Montefiore p; "The Child with Chronic, Recurrent Abdominal Pain" presented by Morris Green, MD, Perry W. Lesh Prof, Chmn Dept ed, Indiana Univ Sch of Med; "Pediatric Emergency Room Radiology" presented by Leonard E. Swischuk, MD, Prof of iol & Ped; Director, Div Ped Radiol, Child Health Ctr, U Texas Medical Branch, and "Anemia in the Newborn" presented Alvin Zipursky, MD, Prof & Chmn, Dept of Ped, McMaster Univ; Program moderator Leo Stern, MD, Prof & Chmn, Sect of roductive & Developmental Med, Brown Univ.

/EMBER 12 and 13

MPOSIUM ON HOSPITAL-ASSOCIATED INFECTION sponsored by New England Chap, Assn for Practitioners in Infec- Control

E: 8:30 am - 4:30 pm
.CE: Providence Marriott Inn
$50 both days, $35 one day only (includes luncheon)
EDIT: 9 hours
NTACT: Pat Miner 277-4773

goal of the symposium is to provide physicians, nurses, hospital administrators, and other health professionals with tinuing education pertaining to the prevention and control of hospital-associated infections. At the conclusion of the gram, participants will have a better understanding of the interdisciplinary and collaborative roles and responsibilities in prevention and control of hospital-associated infections; will be able to identify risk factors associated with surgical nd infections; to comprehend the mechanism for an epidemiologic investigation; to understand the rationale for the itution of control measures necessary to contain nosocomial spread of both virus and bacterial infections; to relate propriateness of current isolation techniques to specific disease entities and, finally, to interpret the legal implications arding hospital-associated infections.

VEMBER 22

NUAL SURGERY SYMPOSIUM "Trends in the Surgery of Trauma" sponsored by Brown Univ, RI Chap American Coll of

Surgeons, RI Hosp Dept of Surgery
TIME: 8:30 am - 12:00 noon
PLACE: George Aud, RI Hosp
FEE: Call for info
CREDIT: 3 hours
CONTACT: Dr. Pitts 421-4121

JANUARY 14, 1981

TOPICS IN HEMATOLOGY sponsored by Brown Univ, Leukemia Soc of America, and RI Hospital, Div of Clin Hematolog
TIME: 9:00 am - 1:00 pm
PLACE: George Aud, RI Hosp
FEE: No charge
CREDIT: Call for info
CONTACT: Dr. Albala 277-5395

Lecturers will be Thomas Myers, MD, Asst Prof of Med, Brown Univ and Assoc Hematologist, Pawt Memorial Hosp; Mu Silverstein, MD, Prof of Int Med, Mayo Med Sch; James D. Simon, PhD, Asst Prof of Med (Res), Brown Univ and Assoc Div of Clin Hematology, RI Hosp.

CME Calendar, Spring-Summer 1981

The deadline for submission of entries for the next CME Calendar is ***November 14, 1980.*** *Please send listings to:* ***Mrs Irene Owens, Brown University, Box G, Providence, RI 02912.*** *General inquiries and requests for extra copies are als available here, or call* ***863-3337.***

Continuing Medical Education Opportunities

EMBER 3

M offering at Newport Naval Regional Med Ctr in conjunction with Naval Health Sciences Educ & Trng Ctr in Bethesda, mand Conf Rm, Bldg #1, 3:00 pm. "Hemophilia—Current Status of Management" presented by Edwin N. Forman, MD, sc Prof of Ped, Brown Univ; Director, Ped Hematology/Oncology, RI Hosp. 2 credit hours. 841-3352.

EMBER 10

M offering at Newport Naval Regional Med Ctr in conjunction with Naval Health Sciences Educ & Trng Ctr in Bethesda, mand Conf Rm, Bldg #1, 3:00 pm. "Anemias in Office Practice" presented by Mario Baldini, MD, Prof of Med Sci, Brown Director, Hematologic Research, Pawt Mem Hosp. 2 credit hours. 841-3352.

EMBER 17

M offering at Newport Naval Regional Med Ctr in conjunction with Naval Health Sciences Educ & Trng Ctr in Bethesda, mand Conf Rm, Bldg #1, 3:00 pm. "Maternal Diabetes and Its Effect on Fetal Development" presented by William Oh, Prof of Ob/Gyn, Brown Univ; Pediatrician-in-Chief, Women and Infants Hosp. 2 credit hours. 841-3352.

OBER 6

RI Dist Branch Mtg, Ray Conf Ctr, Butler Hosp. "The Boston State Hospital Case: Rogers Vs. Oaken. The Right to se Treatment: Implications for Psychiatrists" presented by Stephen Schultz, JD. 1.5 hours credit. 331-0164.

OBER 8

osp House Officers Assn guest speaker, George Aud, Noon. Presentation by Sidney Phillips, MD, Consultant in Gastro-trology, Mayo Clinic. 277-5015.

OBER 14

lon Harrower Memorial Lecture, Day-Kimball Hosp, Putnam CT, 7:00 pm. "Diagnosis and Treatment of Pulmonary olism" presented by Arthur A. Sasahara, MD, Prof of Med and Chief, Med Serv, West Roxbury VA Hosp. 1 hour. 203-928-.

OBER 16

er Oration, Sopkin Aud, Miriam Hosp, 11:00 am. "Computerized Tomography" presented by Joseph Whalen, MD, Chief, of Radiology, NY Hosp, Cornell Med Sch. 274-3700 x 447.

OBER 17

losp House Officers' Assn guest speaker, George Aud, 10:30 am. Presentation by Norman Glazer, MD, Dept of Radi-y, Children's Hosp, Akron, OH. 277-5015.

OBER 20

rterly Scientific Mtg & Annual Dinner, RI Soc of Pathologists, Brown U Faculty Club, One Magee St, 7:00 pm. "Sudden siologic Cardiac Death with Minimal Autopsy Findings" presented by Joseph Davis, MD, Chief Med Exam, Dade Cty, ni; Prof of Pathology, U Miami; Past-President, American Acad of Forensic Sci; Past-President, Dade Cty Med Soc. 1 it hour. 456-2162. Limited to Society members only.

OBER 22

losp House Officers' Assn guest speaker, George Aud, Noon. "Permeability Pulmonary Edema" presented by Jerome S. dy, MD, Dir Pulmonary Med Sect, Univ Hosp, Boston U Med Ctr. 277-5015.

OBER 23

er Hosp Staff Assoc CME Mtg, Ray Conf Ctr, Butler Hosp. "Psychiatry in Medicine" presented by Vivian Rakoff, MD. 0164.

EMBER 17

Hosp House Officers' Assn guest speaker, George Aud, Noon. "Therapy of Glomerulonephritis" presented by Cecil gins, MD, Acting Chief, Renal Unit, Mass Gen Hosp. 277-5015.

UARY 8, 1981

eone Oration, Sopkin Aud, Miriam Hosp, 8:00 pm. Presentation by Francis Moore, MD, Moseley Professor of Surgery, ritus, Harvard Med Sch; Surgeon-in-Chief, Emeritus, Peter Bent Brigham Hosp; and Senior Consul in Surgery, Sidney er Cancer Inst. 274-3700 x 447.

UARY 20

rterly Scientific Mtg, RI Soc of Pathologists, Aud, Women & Infants Hosp, 8:30 pm. "Carcinoma of the Uterine Cervix its Precursors" presented by Stuart Lauchlan, MD, Attending Pathologist, Women & Infants Hosp. 1 credit hour. 456-2.

UARY 21

Hosp House Officers' Assn guest speaker, George Aud, Noon. Presentation by R. Gordon Douglas, MD, Prof of Med & robio; Head, Inf Dis Unit, Strong Mem Hosp, U Rochester Med Ctr. 277-5015.

In the Planning Stage . . . .

Advanced Cardiac Life Support Program, sponsored by RI Hosp and RI Affiliate, AHA, to be held four times a year. C Director will be Steven A. Wartman, MD, Director, Div of Gen Int Med, RI Hosp. Enrollment limited to RI Hosp full faculty, attending staff, house officers, and critical care nurses. 12 credit hours. Registration fee. 277-5015.

Annual Chief Pro Tem Day, Dept of Ophthal, RI Hosp. 277-5509.

Diagnostic Imaging Symposium is being planned for August 13-16, 1981, in Newport, RI. Topics will include: Ultras Nuclear Medicine, CT, and Angiography. 20 credit hours. Registration fee $275. Dr. Scola 277-4700.

Occupational Diseases & Environmental Pathology Conference is being planned for the fall of 1980, Barus Holley 166 o Brown Univ campus. Call Dr. Limehouse 274-3700 x 350.

"Observation of a Group Conducted by an Experienced Group Therapist" is the title of a new course planned for the f 1980. The course is for mental health professionals interested in gaining further skills and training in group therapy. will be a registration fee for those taking the course for training program credit from the Northeastern Soc for G Therapy. Call Dr. Gruen 724-5273.

Patient Compliance Seminar, sponsored by Brown Univ Comm on Cont Med Educ Ray Conf Ctr, Butler Hosp. Tentative early spring, 1981. Call I. Owens 863-3337.

Statewide Cancer Symposium being planned at Miriam Hosp. Call Ms. Welch 274-3700.

Annual Symposium sponsored by the Brown Univ Medical Assn "Controversies in Nutrition", Barus-Holley Bldg o Brown campus. Friday, November 14, 1980 (Homecoming game with Dartmouth on Saturday, November 15). Call I. O 863-3337.

Rhode Island Medical Society sponsored program is planned for the fall. Topic: "Anxiety: A Clinical View". Call 331-32 331-3208.

Anti-Conflict Calendar:

*The **Rhode Island Medical Society** maintains an on-going calendar of medical meetings and affairs. Call us wh you're scheduling — **331-3207 or 331-3208.***

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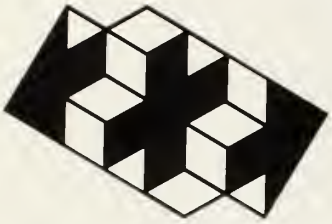

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Rhode Island Medical Society September 1980

Newsletter

Peter L. Mathieu, Jr., MD, Editor
Karen Challberg, Associate Editor

New Ethics Code Approved

In its July 1980 the House of Delegates of the American Medical Association approved the following new rendering of the Principles of Medical Ethics. The action came after more than two years of deliberations and discussions of exact wordings and precise implications of the principles:

Preamble: The medical profession has long subscribed to a body of ethical statements developed primarily for the benefit of the patient. As a member of this profession, a physician must recognize responsibility not only to patients, but also to society, to other health professionals, and to self. The following Principles adopted by the American Medical Association are not laws, but standards of conduct which define the essentials of honorable behavior for the physician.

I. **A physician shall be dedicated to providing competent medical service with compassion and respect for human dignity.**

II. **A physician shall deal honestly with patients and colleagues, and strive to expose those physicians deficient in character or competence, or who engage in fraud or deception.**

III. **A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interests of the patient.**

IV. **A physician shall respect the rights of patients, of colleagues, and of other health professionals, and shall safeguard patient confidences within the constraints of the law.**

V. **A physician shall continue to study, apply and advance scientific knowledge, make relevant information available to patients, colleagues, and the public, obtain consultation, and use the talents of other health professionals when indicated.**

VI. **A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical services.**

VII. **A physician shall recognize a responsibility to participate in activities contributing to an improved community.**

At the July meeting the House also approved a report of the Ad Hoc Committee on the Principles of Medical Ethics which stated: insofar as there have been in the past and will continue to be in the future situations requiring study, expansion, or modification of the Association's ethical stance, a mechanism should be developed to monitor and anticipate events which might call for such modification, so as to assure continuity and to keep current before future generations of physicians the importance and magnitude of their ethical commitment.

RIMS Appointed Committees, 1980-1981

Additions:

Perinatal Committee
*Don B. Singer, MD

Maternal Health
Ronald R. Ricco, MD

* *Member of American Medical Association*

AMA Picks Dan Cloud

Peter L. Mathieu, Jr., MD

Daniel T. Cloud, MD, pediatric surgeon from Arizona, won the Presidency-Elect of the American Medical Association in a closely contested election opposite Thomas Ballantine, MD, neurosurgeon from Boston, Massachusetts at the recent annual meeting of the AMA House of Delegates in Chicago. Dr. Robert B. Hunter of Washington was installed as President.

Dr. Cloud has played an active leadership role in shaping the modern policies of the AMA during his years in the House of Delegates, on the Council on Constitution and Bylaws, and for six years as a busy member of the Board of Trustees.

Upon election he was asked if he believed a single organization such as the AMA could effectively represent the views of physicians in diverse geographical locations and specialties and with differing professional interests. He smiled and responded that the American College of Physicians and the American College of Surgeons do speak for the special interests of their members, which is proper and desirable, but that he believes there are certain things that specialty organizations can not do, which is where the AMA comes in.

The new President-Elect is quick to point out that in Arizona there is still no Medicaid program. He believes we have there a unique opportunity to test ways of providing care with less expense and regulation than under Medicaid. He hopes that we physicians can soon find ways to make membership in all levels of organized medicine — county, state, and national — so desirable that it will be unthinkable to not belong.

As Dr. Dan Cloud joins the leadership team with President Dr. Bob Hunter and Executive Vice-President James Sammons, it seems reasonable to conclude that the interests of the profession and the patient will be in good hands.

AMA Meeting Highlights

• Adopted a new set of ethical guidelines, the first revision of the principles since 1957.

• Reiterated the Association's current policy on national health insurance.

• Urged steps to end the current dual certification of continuing medical education programs.

• Opposed federal subsidies that give HMOs an unfair advantage over other delivery programs.

• Pledged to work to achieve equitable and realistic reimbursement levels for physicians under the Medicare and Medicaid programs.

• Supported efforts to ease restrictions on the availability of CT scanners.

• Emphasized the need for expanded AMA membership and lifted the moratorium on adding specialty society representatives in the house.

• Decided not to accept a request from the American College of Surgeons to withdraw its representative from the AMA house, but to seek a new dialogue on the problem.

• Urged a "go slow" policy on mandatory programs r continuing medical education and recertification p grams.

• Gave support to a government-conducted scient c study of chiropractic.

• Voiced criticism of some policies of the Joint C mission on Accreditation of Hospitals.

Reprinted from *American Medical News*, August 1/8 1980.

Preview • Preview • Preview • Previe

Richard E. Egdahl, MD, professor of surgery a department chairman, Boston University Medi Center; and well-known thinker and theorist ab t innovative health care delivery, has accepted t invitation of the Scientific Work and Annual Meet g Committee of the Rhode Island Medical Society to the **40th Charles V. Chapin Orator** on the occasion f the 170th Annual Meeting of the Society on **May 1981.** A tentative title of his oration is "Competiti and Regulation: Are There Alternatives?".

14 New RI Laws - - 1980

The following bills relating to the delivery of health care were passed during the 1980 session of the Rhode Island General Assembly:

#80-H7081

Title: An Act Relating to Physical Therapists

Summary: This act makes physical therapists subject to the law governing Professional Service Corporations.

#80-H7234

Title: An Act Relating to Procedure in Particular Actions

Summary: This act empowers the presiding justice of the Superior Court to designate another person to appoint members to medical liability mediation panels.

#80-H7398

Title: An Act Mandating Insurance Coverage for Treatment of Alcoholism

Summary: This act requires health insurers to provide coverage for services relating to treatment for alcoholism. The act also establishes a permanent advisory commission to study the feasibility and desirability of mandating third-party coverage of alcoholism treatment.

#80-H7456

Title: Joint Resolution Establishing a Study Comm sion for Health Care Benefits for State Employees

Summary: This resolution establishes a 19-memb commission to study the feasibility of self-insuran for health benefits of state employees, which sh report back to the General Assembly no later than A 1, 1981.

#80-H7473

Title: An Act Relating to Emergency Health Care

Summary: This act prevents health care facilities th have emergency medical care units from delaying denying treatment on the basis of economic status from obtaining such information prior to treatme where the person's health might be affected. Violatio are to be reported to the Director of the Health Depa ment, who is empowered to investigate.

#80-H7499

Title: An Act Relating to Medical Malpractice Trials

Summary: This act provides that after notice of reje tion of the medical liability mediation panel's decisi has been served, the case shall be placed on the tri calendar with a 30-day notice.

#80-H7500

Title: An Act Relating to Proceedings Before the Me cal Liability Mediation Panel

Summary: This act requires the Medical Liabili Mediation Panel to report its findings within 6 mont of the conclusion of discovery.

(continued next pag

nterview of the Month

Mary D. Lekas, MD

r. Mary D. Lekas, surgeon and director of the Resi-ency Training Program in Otolaryngology at Rhode land Hospital, is the newly elected president of the ew England Otolaryngological Society. She is the rst woman to serve as the Society's president.

Besides serving in her new post, Dr. Lekas has active llowships in the American College of Surgeons; the merican Laryngological, Rhinological, and Otological ociety; the American Academy of Otolaryngology and ead and Neck Surgery; the American Academy of acial Plastic and Reconstructive Surgery; and the merican Broncho-Esophagological Association. She a diplomate of the American Board of Otolaryng-logy.

A Worcester native, she is a graduate of Clark Uni-ersity, where she serves as a member of the Alumni ouncil; the University of Athens Medical School; and he University of Pennsylvania Graduate School of ledicine. Presently she is a clinical assistant profes-or in Brown University's Program in Medicine.

Following a year of medical rotation at The Memorial ospital in Worcester, Dr. Lekas completed her esidency in Otolaryngology at Rhode Island Hospital here she became the first woman physician to join hode Island Hospital's surgical staff.

She publishes extensively and has found the time lso for special charitable efforts. She spent several onths on the S.S. HOPE in the port of Colombo, eylon, serving the Project HOPE, which she believes s an excellent program, now land-based.

The future of the health care delivery system nterests and intrigues her. She believes there are many pportunities for doctors to shape this future by orking together. She recommends education on ssues of social and political concern, but first hysicians must not be afraid to admit what they do not now about the system in transition. Then they will nderstand what they need to find out.

Dr. Lekas' family history reveals many teachers, which explains her own interest in education. While attending the Graduate School of Biology at Boston University she was an instructor of human anatomy and physiology, chemistry and microbiology at the Hahnemann Hospital School of Nursing in Worcester, and she has maintained various teaching appointments continually since that time.

Outside of her profession her time is spent skiing, swimming, boating, cycling, walking, dancing, and singing in the church choir, interests which her husband shares with her. She says she owes a great deal to her husband, who has encouraged her professional commitment, helped her, and in doing so has also become an excellent cook.

Dr. Lekas practices in association with Dr. Dinesh Bhat, in the physician office building of the Rhode Island Hospital.

4 New RI Bills (continued)

80-H7660

itle: An Act Relating to Physician's Fees and Health are Facilities

ummary: This act requires any physician who is not a articipant in a medical insurance plan to post a notice a conspicuous place in his medical offices where it an be read by his patients, which shall read, in ubstance, as follows: "To my patients: I do not partici-ate in a medical insurance plan. You should know that ou will be responsible for the payment of my medical ees." Any physician who fails to post such a notice hall not be entitled to charge his patients any amount or medical fees in excess of that allowed had the hysician participated in such a medical insurance lan. The law also provides for similar disclosure by censed health care facilities.

#80-H7826

Title: An Act Pertaining to Licensure and Certificate of Need for Health Care Facilities

Summary: This legislation extends the effective date for implementation of licensure and certificate of need over free standing emergency care facilities one year.

#80-H7827

Title: An Act Pertaining to Certificate of Need for Health Care Facilities

Summary: This legislation repeals coverage of independent clinical laboratories under the state certificate of need law.

#80-H7828

(continued next page)

Negotiations Conference Report

Melvin Hoffman, MD

The national conference "Physicians Negotiating in a Fee-for-Service Environment" held June 16 and 17, 1980 in Washington, DC raised some important basic questions:

1- In the future, who will be the parties in negotiations involving physicians' services, and what will be the subjects of the bargaining? It is anticipated that negotiations will be an increasingly important activity for physicians, not only with third-party payers, but also with the governing bodies in HMOs, IPAs, hospitals, and other health provider settings. Physicians assistants services, secretarial services, as well as key policy concerns such as incorporated in bylaws, will all be likely subjects for bargaining.

2- How does negotiation really work? An important concept stressed at the conference was that for there to be true negotiating both sides must be prepared to readjust their positions as a result of discussions, and in order for this to be so, each side must be in a position to "punish" the other side. Some forms of punishment are arousing public outrage over the other's action, and as a last resort, striking.

3- What are the basic ground rules of negotiations? Simply stated, negotiations should be undertaken only under the following conditions:

a) A party should be extremely knowledgeable on all of the issues surrounding the negotiations.

b) Legal counsel on positions should be obtained prior to negotiations.

c) There should be *one* negotiator chosen to be the *sole* spokesman for a party in negotiations.

The importance of this avenue for influence in t future of the Rhode Island Medical Society is great. T Rhode Island Medical Society will become especia effective in negotiating efforts if it can be the umbre organization for local specialty societies and use aggregate influence in both specialty and total phy cian arenas. The Society should develop a team negotiations to plan for action, which Dr. Peter Mathieu, Jr., President, will suggest to the next me ing of the Council.

OSMAP Elects Mathieu

Dr. Peter L. Mathieu, Jr., President of the Rhode Isla Medical Society, was elected for a three-year term the eight man Steering Committee of the natio Organization of State Medical Association Presider (OSMAP), during its annual meeting in Chicago, Illinc July 21, 1980. Also elected to the Steering Committ at this meeting was Dr. Charles H. Epps of Texas.

The purpose of OSMAP is to further the aims a ideals of medicine by dealing with issues of importan to the medical profession and to society. OSMAP offe an opportunity for interface among representatives the 55 state and territorial medical associations, to t end of enhancing and improving leadership directio in the associaiton. OSMAP is governed by the Steeri Committee, which has the power to act for t organization, conduct its affairs, and it also serves the nominating committee.

At the recent July meeting of this association David H. Carlton of Louisiana was elected Preside Dr. John C. Tupper of California was elected Vice Pre dent; and Donald F. Foy, Executive Director of t Indiana State Medical Association, will serve as Sec tary-Treasurer. Also, members voted to delegate to Jerome Freedman, Past President and chairman for t annual meeting, and to Don Foy, Secretary-Treasur the authority to consult with the American Medi Association in a liaison capacity with regard to OSM activities.

14 New RI Bills (continued)

Title: An Act Pertaining to Licensure and Certificate of Need for Health Care Facilities

Summary: This legislation extends the effective date for implementation of licensure and certificate of need over home health agencies and organized ambulatory care facilities one year.

#80-H7854

Title: An Act Relating to the Catastrophic Health Insurance Plan

Summary: This act removes the Catastrophic Health Insurance Program (CHIP) from the Department of Administration to the Department of Health.

#80-S2300

Title: An Act Relating to the Requirement of Informed Consent in Cases of Abortion

Summary: This act requires full disclosure and formed consent for abortion cases.

#80-S2651

Title: An Act Relating to Physicians

Summary: The effective date for the submission of ve fication of continuing medical education is chang from 1 January to 1 October of every third year. This v allow the processing of the documents prior to t annual renewal date of 1 January. This amendment v also grant authority to the board to waive the edu tional requirements on an individual basis for ju cause.

Reminder:

Mt. Pleasant High School Health Magnet Program still needs physicians to participate beginning in September. Call Dr. Daniel Moore, Jr. at 421-6348 or the Society office at 331-3207. For details, see *Newsletter,* July 1980.

Administrative Reports . . . Meetings with Officers and Staff

Wednesday, July 16, 1980 . . . heard a report from Dr. Melvin Hoffman on the conference titled "Physicians Negotiating in a Fee-for-Service Environment" held June 16 and 17, 1980 in Washington, DC (See News Item) . . . discussed the role of the Rhode Island Medical Society in the negotiations arena . . . Dr. Peter L. Mathieu, Jr. announced that he will present a recommendation to the Council at its next meeting that a special group on negotiations be formed to plan and develop resources for negotiations actions . . . discussed the Rhode Island Medical Society organizational structure and, in particular, the importance of increasing specialty society representation within that structure.

Wednesday, July 23, 1980 . . . meeting cancelled . . . Drs. Mathieu, Metcalf, Millard, Cunningham, and Hager were attending Chicago meeting of the AMA House of Delegates.

Wednesday, July 30, 1980 . . . heard a report from Dr. Charles L. Hill on Society affairs during the week July 21-25, 1980 . . . Dr. Mathieu reported on interviews in Chicago with some candidates for the position of Executive Director . . . Howard E. Lawton reported on the meeting of the Impaired Physicians Committee held July 22, 1980 . . . discussed the need to assure that there is legislation granting immunity to members participating in this and similar programs . . . Dr. Mathieu discussed the importance of renewing Society efforts in the emergency medical services arena through the new Trauma Committee . . . Dr. Metcalf reported on contacts made while in Chicago and possibilities for gaining statistical help on medical manpower issues . . . Dr. Mathieu expressed views on future roles of PSROs, HSAs, and SHCC type councils based on present trends of thought in federal government and congressional circles . . . Dr. Metcalf requested support in obtaining quantified evaluations of SNF services on the west coast for comparison with Rhode Island services . . . discussion followed of the importance of estimating the cost of surveillance and regulation of nursing and other health care facilities . . . Dr. Hill explained the importance for both health provider institutions and the government of accounting systems based on disease related groups, but with flexibility because there are vast differences between cases . . . discussion followed of systems proposed for reimbursing physicians on a standard per hour basis and the benefits and drawbacks of these systems . . . heard a report on plans for future issues of the Rhode Island Medical Society *Newsletter* . . . Dr. Erminio Cardi recommended the concept-highlight approach in the *Newsletter* . . . Dr. Mathieu urged the importance of allowing for airing of controversial issues in the *Newsletter* . . . discussed the importance of obtaining a license to carry on insurance brokerage activities as soon as possible . . . Mrs. Rattigan was asked to set up a date for Drs. Cardi, Hill and Mathieu to meet with Mr. Ray Bolster of Ward, Fisher and Company on the Rhode Island Medical Society budget to be presented to the Council at its meeting in October.

Wednesday, August 6, 1980 . . . guests of the meeting were Rhode Island Department of Health staff members Williams J. Waters, PhD, Assistant Director — Health Policy; Bruce C. Kelley, PhD, Chief, Office of Health System Planning; and Donald C. Williams, Supervising Health Planner, Office of Health System Planning . . . Dr. Paul B. Metcalf, Jr. presented a report on alternative methods of measuring physician manpower supply . . . four methods referred to in the report included (1) manpower to population ratio, (2) perceived need quotient, (3) estimated supply and demand, and (4) a combination of need and supply and demand . . . lengthy discussion followed the report . . . Rhode Island Medical Society and Department of Health will work together (1) to review data collection methods used in Rhode Island, and (2) to educate physicians to the importance of accurate manpower data reporting. Dr. Mathieu appointed Dr. Metcalf; Donald C. Williams; Mr. Robert McClanaghan, Division of Professional Regulation; and Dr. Richard G. Bertini to form a steering committee to implement these goals . . . next meeting with Department of Health officials will be September 3, 1980 . . . reviewed Council agenda for upcoming meeting, August 18, 1980.

New Offices, New Locations

Michael S. Barrett, MD
834 Main Street
Warren, Rhode Island 02885
(General and Vascular Surgery)

Jit Kaur Chadha, MD
655 Broad Street
Providence, RI 02907
(Obstetrics and Gynecology)

Frederick S. Crisafulli, MD
909 North Main Street
Providence, RI 02904
(Internal Medicine)

Victor Formisano, MD
182 Waterman Street
Providence, RI 02906
(Dermatology)

Frederick M. Johnson, MD
1524 Atwood Avenue
Johnston, RI 02919
(Orthopedic Surgery)

Robert G. McRae, MD
100 Dudley Street
Providence, RI 02905
(Otolaryngology and
Head and Neck Surgery)

Christopher J. Morin, MD
1351 Smith Street
North Providence, RI 02911
(General and Vascular Surgery)

Barry B. Schwartz, MD
909 North Main Street
Providence, RI 02904
(Internal Medicine)

Sanford C. Spraragen, MD
909 North Main Street
Providence, RI 02904
(General and Cardiovascular
Nuclear Medicine)

Aches and Pains . . .

• A Maryland bill, approved on May 6, 1980 and effective on July 1, 1980, requires that "all privately owned and commercially operated indoor racket sports facilities shall have on the premises at all times during business hours personnel who are certified to administer cardiopulmonary resuscitation" (Chapter 363, Laws, 1980).

• The new blood level chart on therapeutic, toxic and lethal blood levels, titled *Drug and Chemical Blood Level Data, 1980,* will be available after August 1980. This is the popular blood level table produced by Fisher Scientific, 711 Forbes Avenue, Pittsburgh, PA 15219. Copies may be obtained by writing directly to Mr. Jack Daniels, Director of Marketing at Fisher Scientific.

• In 1979, Medicare served 24.6 million aged and 2.9 million disabled beneficiaries or 12 per cent of the US population, costing $28.2 billion in direct benefit payments. These and other statistics can be found in the recently released *13th Annual Medicare Report* covering fiscal 1979. Copies are available by writing to: HCFA, Printing and Publications Branch, 1710 Gwynn Avenue, Room D-3, Baltimore, MD 21235, or by calling Brody Whitlock, 301 594-5514.

• The Blue Cross Association recently announced an experimental hospital payment plan that will pay hospitals on the basis of the average cost of care for a defined subscriber population. The size of the payment will vary according to the actuarial estimate of service costs based on demographic characteristics ra than hospital characteristics. The amount will be according to such characteristics as age and sex ra than on the hospital's operating expenses.

• The Center for Disease Control recommendati for 1980-1981, based on last year's predominant st of influenza virus in the US, B/Singapore/79, have b released. A trivalent vaccine will be available for ministering in one dose to persons 28 years and ol and in two doses to those under 28 who did not rec at least one dose of the 1978-1979 or 1979-1980 triva vaccine. It will come in whole-virus and split-virus parations.

• The Rhode Island Department of Health published notice that it will not be subsidizing influenza vaccine this fall. For several years it provi this service with the help of federal funds which will be forthcoming this year. The Immunization Counci advising agencies and physicians in time for them make decisions about purchasing the vaccine fr pharmaceutical companies.

• The National Center for Health Statistics (NC recently published a report entitled *Issues Regard Confidentiality of Data in the Cooperative He Statistics Systems,* in which legislative, practical, philosophical aspects of handling data with confid tiality are discussed. Some problem areas are identif and remedial courses of action suggested. Sin copies are available free from NCHS, Room 1-57, Cen Building, 3700 East-West Highway, Hyattsville 20782, Attn: M. Murray.

Medical Meetings

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September

2 Executive Committee, Staff Physicians Association of Rhode Island; meeting.
8 Staff Physicians Association of Rhode Island; regular meeting; Roger Williams General Hospital.
17 Annual Golf Tournament and Dinner (Providence Medical Association).
18 Pawtucket Medical Association; meeting; Checker Club, Benefit Street, Pawtucket; speaker: Peter L. Mathieu, Jr., MD "Problems Facing Medical Societies and Physicians in the 1980s"; 6:30 pm; (fee for non-members $10.00).
22-24 Irish-American Pediatric Society; Cork, Ireland.
24 Rhode Island Medical Society House of Delegates; regular meeting; 2:00 pm.
* Arthur E. Hardy Memorial Golf Tournament and Dinner (Kent County Medical Society); Warwick Country Club.

October

1 Rhode Island Chapter; American Academy of Pediatrics; regular meeting; Newport; evening.
2 Blue Cross Board; regular meeting; 5:30 pm.
6 Rhode Island Medical Society Council; regular meeting; 6:00 pm.
8 Miriam Hospital Staff Association; outing and dinner dance; Kirkbrae Country Club.
8 New England Pediatric Society; fall meeting.
8 Washington County Medical Society; regular meeting; Mental Health Building; Westerly; afternoon.
11 New England State Medical Societies; regular meeting; Sheraton Sturbridge Inn, Sturbridge, Massachusetts (rooms, sui available; call 413 736-7301 to make it a weekend).
14 Providence Surgical Society; regular meeting.
17-18 Third National Invitation Conference for Physician Negotiators; Hilton Hotel, Las Vegas, Nevada.
18-19 New Society of Allergy; fall meeting; Sheraton-Islander Inn; Newport.
20 Blue Shield Board; regular meeting; 6:00 pm.

November

5 Rhode Island Medical Society sponsored conference (subject to be announced).
11 Rhode Island Society of Allergy; fall meeting; University Club; 6:30 pm.
12 Providence Medical Association; regular meeting; Roger Williams General Hospital dining room.

* Date undecided

PRESIDENT'S CORNER

Peace, Harmony, and Problems

The Rhode Island Medical Society is 169 years old; the charter of incorporation was granted February, 1812. Article II of our Bylaws states: "The objects of this Society are to promote the science and the art of medicine and the betterment of public health; to promote friendly intercourse among physicians; to enlighten and direct public opinion in regard to the problems of medicine." In the eyes of your president, the goals of the Rhode Island Medical Society, so stated in 1812, remain a solid base on which to build. The codified rules and bylaws of the Rhode Island Medical Society, as amended to May 14, 1980, are presently in preparation and will be in the hands of members shortly.

This issue of the *Rhode Island Medical Journal* carries a table of organization of the Rhode Island Medical Society (page 323). Emerson defined an institution as "the lengthened shadow of a man". Certainly, our medical society is the "lengthened shadow" of many courageous men and women. While the year 1812 marked the founding of the Society, there have been many significant milestones in its history, as recorded in its archives. It is pertinent to recall the long-time executive director of the Rhode Island Medical Society (38 years), John E. Farrell, who retired in January, 1974. Your president, at the time was president of the Providence Medical Association, the largest district medical society in Rhode Island (850 members).

Then, during the period from 1974 to 1980 there were two executive directors. Timothy Norbeck (1974 to 1977) served the Society well. For personal reasons he transferred to a larger state medical society with an enrollment three times the size of that of the Rhode Island Medical Society. The Connecticut State Medical Society and the Rhode Island Medical Society have much in common in this southeastern corridor of New England, and our sense of loss at Tim's departure has been softened by the bridge he built between the two neighboring state medical societies. In November, 1977 James R. Clarkin became the executive director; and held the position until July 1, 1980 when he retired to the life of a country gentleman in Yarmouth, Cape Cod, Massachusetts.

Peter L. Mathieu, Jr., MD

The Council at its March, 1980 meeting directed the then President, Dr. Charles L. Hill, to appoint a Management Committee charged with the task of studying the staff structure of the Society and making recommendations for its improvement. I am the Chairman of this committee with Doctors Charles L. Hill, Kenneth E. Liffmann, Erminio Cardi, Charles Millard, and Paul Metcalf, Jr. as members. In a preliminary report to the Council at its June 9, 1980 meeting the Management Committee noted that it had found its task to be extensive, and it recommended to the Council that it be authorized to continue for at least one more year to arrive at some solutions to the problems surfaced by the Committee during its studies. The Council approved this recommendation.

The Council has directed the Management Committee to serve also as a Search Committee for the new executive director. The Committee has received over 100 applications for the position. This administration believes that the executive directorship of the Society is not a job, but a way of life.

Among the guidelines the Committee has developed to help it to select the right person are the following:

1. *Administrative Skills:* The proper person must have a solid background and experience in

telling people what to do, and in decision making. He must work closely with the elected officers of the society, members of the Council, members of the House of Delegates, committees, and the membership-at-large. He must not be afraid to be wrong or even displease some people. The Committee is looking for a "boss" who will be a good hitter and is not afraid of a bean ball.

2. *Attitude Towards Doctors:* Thinking positively, the "boss" must respect doctors for the work and dedication they have had to apply in order to get to be physicians in the first place. Doctors are "runners". With an understanding that doctors are above the usual run-of-the-mill citizen, the "boss" must work with all the "runners" slow and fast if the Rhode Island Medical Society is going to prevail in keeping its own house in order, while at the same time providing leadership to the community in matters concerning health.

3. *Health:* Good health and abundant energy are essential. We need a person with guts and drive, and the willingness to face the reality that there is never a waking moment in his life when he is not our medical society executive. He needs a mind, a strong body, and must be cool, calm, controlled, competent, and committed.

4. *Public Appearance and Communication Skills:* His "command presence" will make him a salesman for the physicians. His ability to translate the ideas propounded by physicians into clear English free of jargon and persiflage will permit him to meet the media and the public, and represent the profession convincingly and pleasingly.

5. *Education:* This is a bit stickier. An educated man is more often a learned man. Knowledge of management policy, finance (very important), and legislation, are essential. The Management Committee will make every effort to recommend to the Council candidates who would serve the membership well, and safely guide the organization in this transition period and through the turbulent 1980s.

The American Medical Association invitational study of the Rhode Island Medical Society, "A suggested Guide for Organization and Action" (1974), is available to any member upon request. In its report the AMA noted that the Rhode Island Medical Society, typical of most state medical associations throughout the country, is operating in an era of rapid social, political and economic change. The pressures on staff and leadership have increased tenfold in the past two decades. The new "consumerism" and the increasing government involvement with medical practice and health care delivery have utterly transformed the Society's obvious, accepted traditional roles. Both medical and executive leadership must appreciate the need for continuing reappraisal of its positions, its goals and its programs. The AMA survey of 1974 offers a blueprint for an effective administrative organization combined with an effective policy making structure, designed to cope with today's demands. This report is relevant to 1980, and worth reading.

The Society staff consists of the executive director, two assistant directors, two full time secretaries, a part-time bookkeeper, a librarian, and an assistant librarian.

I believe the Society has an extremely dedicated staff, but it needs a personnel manual, job descriptions, job evaluations, and other pertinent written policies to help it to properly serve the membership. The salaries of the executive staff are on the modest side. The salaries of the secretarial staff range from modest to high. Staff benefits have greatly improved since the AMA study of 1974, so that salaries and fringe benefits are now competitive in the general community.

Pursuant to the AMA recommendations of 1974 the Management Committee is reviewing all personnel policies. Members of the staff whose functions are either unique or supervisory must have a manual of operations and job descriptions to go by. Also, the Management Committee hopes to identify the priorities of wages, functions, depth and length of service and to recommend projected policies to the Council.

In studying the organizational structure of the Rhode Island Medical Society the Management Committee must of necessity also consider the finances of the Society. The AMA in 1974 reported that, "the current accounting system of the Rhode Island Medical Society is inadequate in that it does not assure satisfactory internal control, nor does it provide financial data necessary for good physical management. A small Society like the Rhode Island Medical Society does not require sophisticated financial reporting systems. The Rhode Island Medical Society's system, however, is overly simplistic".

Examination of working copies of the Rhode Island Medical Society and *Rhode Island Medical Journal* budgets for the year ending December 31, 1979, indicates that an antiquated cash or anecdotal system continues in operation. This administration believes it leaves room for abuses. It does not give a true picture of income and expenses for the Rhode Island Medical Society. In a May 9, 1980 report by the Society's certified public

(Continued page 325)

Rhode Island Medical Society

Organizational Structure

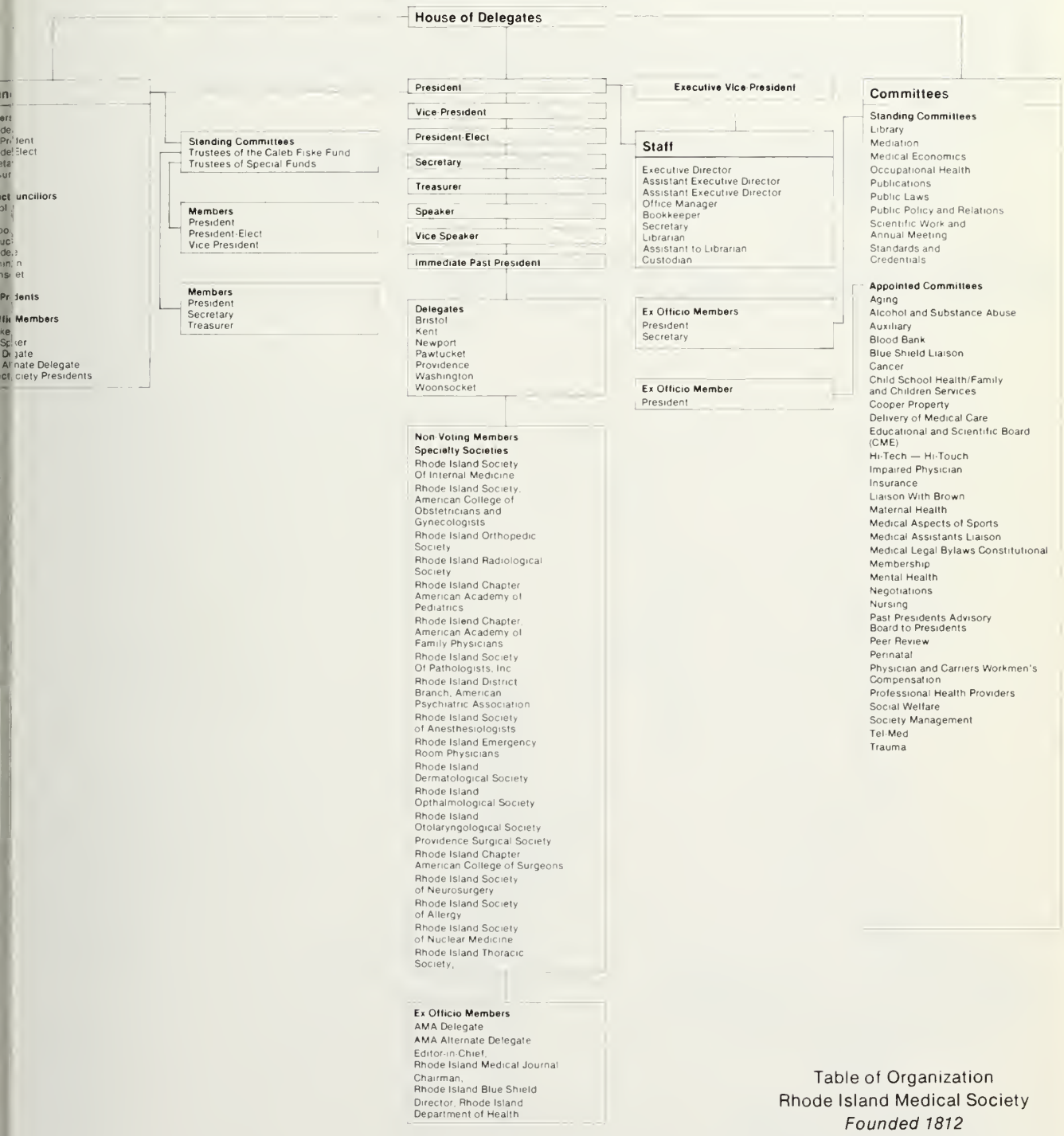
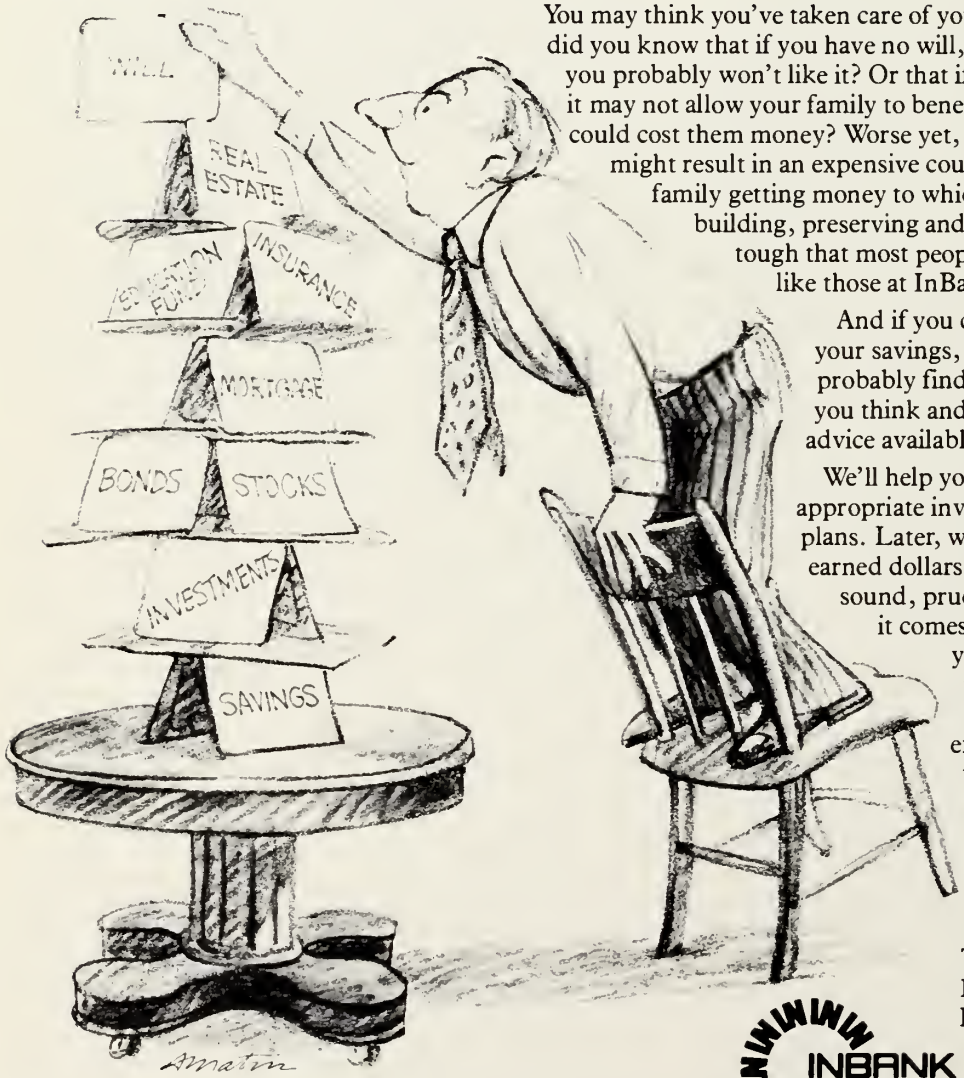


Table of Organization
Rhode Island Medical Society
Founded 1812
Peter L. Mathieu, Jr., MD - President

You may think your family's financial future is secure. You could be dead wrong.



You may think you've taken care of your family's financial future, but did you know that if you have no will, the state has one for you, and you probably won't like it? Or that if your will was written before 1976, it may not allow your family to benefit from changes in tax laws, which could cost them money? Worse yet, if your will is poorly written, it might result in an expensive court contest and cause a delay in your family getting money to which they are entitled. The point is, building, preserving and distributing your assets is a job so tough that most people need help from professionals, like those at InBank.

And if you consider the values of your home, your savings, insurance and investments, you'll probably find that you're worth a lot more than you think and could benefit from the expert advice available at InBank.

We'll help you build your estate now with the appropriate investment strategies and tax-saving plans. Later, we'll help you preserve your hard earned dollars by using tax shelters, and offering sound, prudent financial advice. Finally, when it comes to planning for the distribution of your estate, we'll make sure that your will takes advantage of all available tax savings. Then we'll execute it professionally, according to your wishes.

Call us. We'll make sure your family's financial future is secure, top to bottom. Call Gregory Ahern at (401) 278-6699, or write him at Industrial National Bank, Trust and Investment Division, 100 Westminster Street, Providence, Rhode Island 02903

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accountants to the treasurer, it is noted that "it is the policy of the Society to prepare its financial statements on the basis of cash receipts and disbursements; consequent revenue and related assets are recognized when paid rather than when the obligation is incurred. Accordingly, the accompanying financial statements are not intended to present financial position and results of operation in conformity with generally accepted accounting principles".

This administration recommends that the Society adopt an accrual type bookkeeping system which would (a) identify cash immediately; (b) provide a complete understanding of expenses (both paid and unpaid, while making monies available to pay expenses); and (c) provide a better and more concise balance sheet and income statement. Your officers are exploring this avenue with the Society's auditors. This administration foresees that the Society by restructuring balance sheets on the accrual system basis, will be able to analyze the related statements of revenues, expenses, transfers, and changes in front balances for the year studied. It will thus be able to include such tests of the accounting records and such other auditing procedures as it deems necessary. It is expected that in the future the auditors will give not a partial evaluation of the financial health of the medical society, but an unequivocal opinion that the statement of operations and financial position of the Rhode Island Medical Society is in conformity with "generally accepted accounting principles".

The Society runs on a twelve-month fiscal basis from January 1 to December 31 of each year. Salary increases will be considered on the first of January of the year under consideration. The Management Committee has recommended that the draft of the personnel policy manual of the Rhode Island Medical Society presently being compiled remain a draft until the Medical Society has a new full-time executive director capable of running the Medical Society on a contemporary basis.

The Council, upon the recommendation of the president, accepted the appointment of Doctor Charles L. Hill, immediate past president, as temporary executive vice president of the Society. This is an extremely sensitive position and one which most medical societies have adopted. The executive vice president serves as a liaison person between the elected officers, the Council, membership, the president, and the executive director. This administration holds business management meetings each Wednesday at 9:30 AM in the Library to implement the policies of the Society. This method is working extremely well. I invite all members to come to at least one of these meetings to understand better the complexity of problems currently associated with running a medical organization.

While considerable effort is being expended in the search for a new executive director and while this is progressing in an atmosphere of peace and harmony, this administration must report that we need the help of everyone in planning for the future. What is the purpose of the Society? Should it remain what it is? Should its responsibilities change? In the organizational structure of the Society we have addressed ourselves to the staff and to finances. A fresh objective perspective into the 1980s must include a look at the structure of the House of Delegates, the nature and duties of the officers, the makeup of the Council, the subsidiaries of the Society, including the *Rhode Island Medical Journal,* the Medical Society Library, the Educational and Scientific Board (CME) organization, and elected and appointed committees.

Your president, if he is to act as leader of the profession in the state, must spend at least 30 hours a week in conducting Society affairs. Should he be paid? Is one year sufficient time for the president to perform adequately? Should the vice presidency, which up to now has usually been a dead end, be updated and become a step in learning the processes of running the Society and a step toward the positions of president-elect and president of the Society. Should the district societies become more involved with the state Society, and in what manner? Should the specialty societies become involved with the state Society, and in what manner?

This administration believes that unless the individual physician, the district societies, and the specialty societies aggregate their expertise into a power base they will be overwhelmed by the consumerism of the 1980s. Only by combining forces can the physicians in the state maintain their professionalism and effectiveness. Credibility is very important if we are to leave a legacy for the physicians of the future practicing medicine in the state of Rhode Island. Do we have it now? There is much expertise among Rhode Island physicians. This administration sees evidence of individual doctors accomplishing and performing very well. This administration is not so certain, however, that we have a firm handle on the broader problems of medicine relating to health care delivery and the consumer in the community. Such problems must be dealt with. We need suggestions of everyone. Some of the problems will be solved during this administration. We seek your guidance and the

wisdom of the Council for direction in continuing our efforts to carry out the stated purposes of the Society. We shall identify and speak more thoroughly on specific matters of concern on future occasions in this President's Corner.

Peter L. Mathieu, Jr., MD
President

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- Will alter to suit tenants
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FOR INFORMATION CALL

Howard E. Lawton
Rhode Island Medical Society
331-3207

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rear of The Woonsocket Hospital
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1000 and 1400 sq. ft.
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15 physician occupants
Reasonable rent, purchase option
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Providence, RI 02903
or call
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EDITORIALS

Ultracare

Medicare has a number of deficiencies, which have been exaggerated by inflationary pressures. Blue Cross of Southern California is attempting to make up for some of these deficiencies in an experimental and innovative program in Santa Barbara, to which it has given the name Ultracare. It begins with basic provisions similar to those of Plan 65 of Blue Cross and Blue Shield of Rhode Island by paying the coinsurance and deductibles of federal Medicare Parts A and B.

It also provides benefits for items usually excluded from Medicare supplemental programs, such as hearing aids, dental care, vision care, and comprehensive health care. The comprehensive health care comprises private duty nursing (probably an elusive benefit), hospice services delivered in the home, periodic checkups, eye and ear examinations, and home health care services including light housekeeping services (such as dusting, vacuuming, and making beds) provided by Geriatric Home Aides, one meal delivered to the patient's home if necessary, and even a weekly trip for shopping or medical and dental care.

The subscribers will obtain all of their medical care through a non-profit medical foundation clinic of 50 multi-specialty physicians and their dental care through a dental group. Each subscriber will select a participating physician or dentist as his primary care attending physician or dentist. The plan was designed by Blue Cross of Southern California, working with a Senior Citizens Advisory Committee.

It is not evident from the available information whether the HMO-like group is an independent practice association or a closed group. It is clear, however, that subscribers are confined to an HMO-type set-up without completely full choice of physicians, consultants, or dentists. Although the subject is not addressed, it appears that reimbursement for fees will conform to federal determinations of usual, customary, and reasonable. There is no consideration given to prolonged nursing home care, whether skilled or intermediate, which has pauperized many individuals and families. This remains an unsolved major problem.

Reimbursement for many routine medical services, such as eye examinations, not now paid for, however, fills a gaping void in Medicare Part B. Only time will tell whether all of this generous and desirable service can be provided at a reasonable cost. It is certainly a worthwhile attempt to make up for some of the glaring inadequacies of federal Medicare and deserves our close observation.

Exotica

The *JAMA* Reference Directories are interesting reading. We have in the past listed some of the more intriguing entries. Herewith is our latest selection: Aerospace Medical Association, Ambulatory Pediatric Association, American Academy of Psychiatry and the Law, American Academy of Psychoanalysis, American Association for Automotive Medicine, American Association of Physicians Practicing the Transcendental Meditation, American Association for the Study of Headache, American Chinese Medical Society, American Clinical and Climatological Association, American College of Chemosurgery, American College of Utilization Review Physicians, American Medical Tennis Association, Society for Clinical and Experimental Hypnosis, Society of Computer Medicine, Prolotherapy Association, Noah Webster Dermatological Society, and American Society of Bariatric Physicians.

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RADIOGRAPHIC CASE OF THE MONTH

History:

Twenty-five year old male with a history of chronic swelling of the left knee and recurrent episodes of joint pain.

Radiographic Findings:

The left knee demonstrates joint swelling with lobular soft tissue masses. Cyst like areas are seen involving the distal femur and proximal tibia. No significant abnormalities of the right knee are noted.

For diagnosis and discussion turn to next page.

RADIOGRAPHIC CASE OF THE MONTH

Diagnosis:
Pigmented villonodular synovitis.

Discussion:
Pigmented villonodular synovitis is a chronic proliferative disease that primarily affects young adults. It is a monoarticular arthritis that occurs most commonly in the knee. The knee is involved in approximately half of the cases with the hip, ankle, wrist, shoulder, and small joints all being reported as other sites of involvement. When there is involvement of small joints, this lesion has been called giant-cell tumors of tendon sheaths and xanthomas.

Radiographically, synovial proliferation is reflected by extensive soft tissue thickening, often lobulated and obliterating soft tissue planes. The lobular soft tissue masses may extend beyond the capsule or rarely be entirely extracapsular. The soft tissue masses appear dense secondary to hemosiderin deposits. These masses do not calcify.

Endosteal villonodular synovitis is a term developed to indicate erosion or invasion of bone in this condition. The bone invasion is usually subchondral or involves the articular margins. Cyst like defects of varying size may be present with sharp and sclerotic margins. These bone erosions more often occur in tightly encapsulated joints such as the hip, wrist and small joints of the hands.

Arthrography may be helpful in arriving at a more definitive diagnosis. Double contrast arthrography using contrast material and air will demonstrate the enlarged joint cavity and marked irregularity of the synovium. The irregularities are secondary to synovial nodules.

Though this entity appears to be an inflammatory process there is not a significant hyperemic component to the pathologic process. This in combination with limited disability results in only minimal osteoporotic changes.

Differential Diagnosis:
The usual absence of joint space narrowing and regional osteoporosis serves to differentiate this condition from other synovial processes particularly tuberculosis, rheumatoid arthritis and hemophilia. Lack of calcification aids in differentiation from synovioma. Accurate diagnosis from roentgen examination alone may be extremely difficult. Endoscopic exploration, or surgical exploration, or both, are usually required to establish the diagnosis with certainty and are indicated in order to completely differentiate the lesion from synovial-sarcoma.

Allan M. Deutsch, MD
Michael J. Ryvicker, MD
Howard Cohen, MD
Sanford Schatz, MD

References

[1]Aegerter E, Kilpatrick JA: Orthopedic Diseases, ed 3. Philadelphia, WB Saunders Co, 1968.
[2]Freiberger RH, Kaye JJ: Arthography. New York, Appleton-Century-Crofts, 1979.
[3]Murray RV, Jacobson HG: The Radiology of Skeletal Disorders. Baltimore, Williams and Wilkins, 1971.

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CONTRAINDICATIONS: Because of the quinine content, Quinamm is contraindicated in women of childbearing potential, in pregnancy, in patients with known quinine sensitivity, and in patients with glucose-6-phosphate dehydrogenase deficiency. Hemolysis (with the potential for hemolytic anemia) has been associated with a G-6-PD deficiency in patients taking quinine.

PRECAUTIONS: Thrombocytopenic purpura may follow the administration of quinine in highly sensitive patients. Recovery will follow withdrawal of the medication.
Cinchona alkaloids, including quinine, have the potential to depress the hepatic enzyme system that synthesizes the vitamin K-dependent factors. The resulting hypoprothrombinemic effect may enhance the action of warfarin and other oral anticoagulants.

ADVERSE REACTIONS: Aminophylline may produce intestinal cramps in some instances, and quinine may produce symptoms of cinchonism, such as tinnitus, dizziness, and gastrointestinal disturbance. If ringing in the ears, deafness, skin rash, or visual disturbances occur, the drug should be discontinued.

DOSAGE AND ADMINISTRATION:
1 tablet upon retiring. When necessary, 1 additional tablet may be taken following the evening meal.

Product Information as of September, 1977

U.S. Patent 2,985,558

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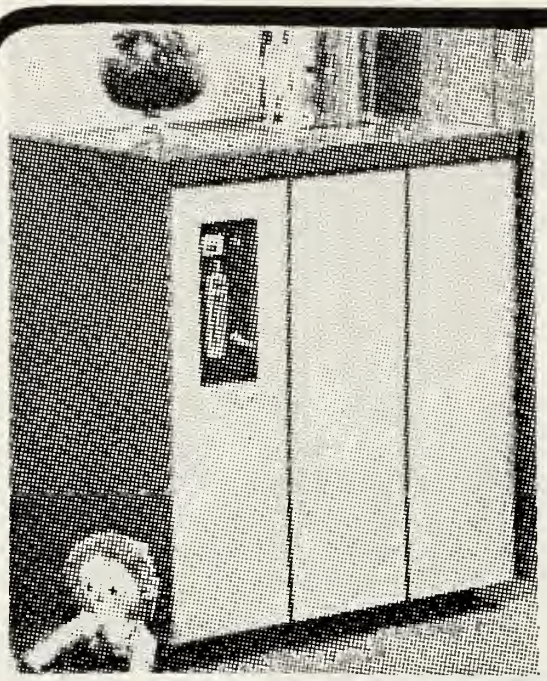

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Brief Summary

INDICATION Tenuate and Tenuate Dospan are indicated in the management of exogenous obesity as a short term adjunct (a few weeks) in a regimen of weight reduction based on caloric restriction. The limited usefulness of agents of this class should be measured against possible risk factors inherent in their use such as those described below.

CONTRAINDICATIONS Advanced arteriosclerosis, hyperthyroidism, known hypersensitivity or idiosyncrasy to the sympathomimetic amines, glaucoma. Agitated states. Patients with a history of drug abuse. During or within 14 days following the administration of monoamine oxidase inhibitors, hypertensive crises may result.

WARNINGS If tolerance develops, the recommended dose should not be exceeded in an attempt to increase the effect; rather the drug should be discontinued. Tenuate may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle; the patient should therefore be cautioned accordingly. *Drug Dependence.* Tenuate has some chemical and pharmacologic similarities to the amphetamines and other related stimulant drugs that have been extensively abused. There have been reports of subjects becoming psychologically dependent on diethylpropion. The possibility of abuse should be kept in mind when evaluating the desirability of including a drug as part of a weight reduction program. Abuse of amphetamines and related drugs may be associated with varying degrees of psychologic dependence and social dysfunction which, in the case of certain drugs, may be severe. There are reports of patients who have increased the dosage to many times that recommended. Abrupt cessation following prolonged high dosage administration results in extreme fatigue and mental depression; changes are also noted on the sleep EEG. Manifestations of chronic intoxication with anorectic drugs include severe dermatoses, marked insomnia, irritability, hyperactivity, and personality changes. The most severe manifestation of chronic intoxications is psychosis, often clinically indistinguishable from schizophrenia. *Use in Pregnancy.* Although rat and human reproductive studies have not indicated adverse effects, the use of Tenuate by women who are pregnant or may become pregnant requires that the potential benefits be weighed against the potential risks. *Use in Children.* Tenuate is not recommended for use in children under 12 years of age.

PRECAUTIONS Caution is to be exercised in prescribing Tenuate for patients with hypertension or with symptomatic cardiovascular disease, including arrhythmias. Tenuate should not be administered to patients with severe hypertension. Insulin requirements in diabetes mellitus may be altered in association with the use of Tenuate and the concomitant dietary regimen. Tenuate may decrease the hypotensive effect of guanethidine. The least amount feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdosage. Reports suggest that Tenuate may increase convulsions in some epileptics. Therefore, epileptics receiving Tenuate should be carefully monitored. Titration of dose or discontinuance of Tenuate may be necessary.

ADVERSE REACTIONS *Cardiovascular.* Palpitation, tachycardia, elevation of blood pressure, precordial pain, arrhythmia. One published report described T wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride. *Central Nervous System.* Overstimulation, nervousness, restlessness, dizziness, jitteriness, insomnia, anxiety, euphoria, depression, dysphoria, tremor, dyskinesia, mydriasis, drowsiness, malaise, headache, rarely, psychotic episodes at recommended doses. In a few epileptics an increase in convulsive episodes has been reported. *Gastrointestinal.* Dryness of the mouth, unpleasant taste, nausea, vomiting, abdominal discomfort, diarrhea, constipation, other gastrointestinal disturbances. *Allergic.* Urticaria, rash, ecchymosis, erythema. *Endocrine.* Impotence, changes in libido, gynecomastia, menstrual upset. *Hematopoietic System.* Bone marrow depression, agranulocytosis, leukopenia. *Miscellaneous.* A variety of miscellaneous adverse reactions has been reported by physicians. These include complaints such as dyspnea, hair loss, muscle pain, dysuria, increased sweating and polyuria.

DOSAGE AND ADMINISTRATION Tenuate (diethylpropion hydrochloride): One 25 mg. tablet three times daily, one hour before meals and in midevening if desired to overcome night hunger. Tenuate Dospan (diethylpropion hydrochloride) controlled-release: One 75 mg. tablet daily, swallowed whole, in midmorning. Tenuate is not recommended for use in children under 12 years of age.

OVERDOSAGE Manifestations of acute overdosage include restlessness, tremor, hyperreflexia, rapid respiration, confusion, assaultiveness, hallucinations, panic states. Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea and abdominal cramps. Overdose of pharmacologically similar compounds has resulted in fatal poisoning, usually terminating in convulsions and coma. Management of acute Tenuate intoxication is largely symptomatic and includes lavage and sedation with a barbiturate. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendation in this regard. Intravenous phentolamine (Regitine®) has been suggested on pharmacologic grounds for possible acute, severe hypertension, if this complicates Tenuate overdosage.

Product Information as of April, 1976

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References 1. Citations available on request from Medical Research Department, MERRELL-NATIONAL LABORATORIES, Cincinnati, Ohio 45215. 2. Hoekenga, M.T., O'Dillon, Dillon, R.H. and Leyland, H.M.: A comprehensive review of diethylpropion hydrochloride. In Central Mechanisms of Anorectic Drugs, S. Garattini and R. Samanin, Ed., New York, Raven Press, 1978, pp. 391-404.

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Final classification of the less-than-effective indications requires further investigation.

Contraindications: Glaucoma, prostatic hypertrophy, benign bladder neck obstruction; hypersensitivity to chlordiazepoxide HCl and/or clidinium Bromide.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium® (chlordiazepoxide HCl/Roche) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) reported following discontinuation of the drug.

Usage in Pregnancy: **Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.**

As with all anticholinergics, inhibition of lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression. suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established.

Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated; avoidable in most cases by proper dosage adjustment but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets

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Pediatric Nephrology in Rhode Island: Experience of the Child Development Center Renal Clinic

Significant Progress in Diagnosis and Treatment Has Been Made

Andrew S. Brem, MD
J. Gary Abuelo, MD

Pediatric nephrology has come a long way since John Blackall's essay on the blotted nephrotic young child in 1818[1] and Richard Bright's vivid description of acute glomerulonephritis in 1833.[2] Advances in diagnosis and treatment over the last twenty-five years, in fact, have affected patients with renal disease more than in any other previous time period. The purpose of this report is to provide an update on these advances in renal diseases as they affect children in Rhode Island.

Patient Population

The Child Development Center (CDC), supported by the Rhode Island Department of Health and housed in the Rhode Island Hospital, has offered renal consultative care since 1970. Over the past nine years, 127 children have been evaluated by the CDC pediatric renal clinic. As of October 1979, 69 of these patients were actively followed by the clinic with a wide range of disorders as seen in Table 1. Glomerular diseases amounted to 46 per cent of the total population with 23 of these children initially presenting with nephrotic syndrome. With an incidence of approximately 1 in 50,000 children under 16 years of age,[3] nephrotic syndrome in 24 children in Rhode Island's population of almost one million people, slightly exceeds national statistics. This may be in part due to referral of patients from outside the state. As would be expected from a pediatric population, 19 per cent of patients were followed for renal hypoplasia, dysplasia, or some form of cystic disease. Developmental renal defects were often associated with either a functional or anatomic urinary tract obstruction. Since asymptomatic hematuria has a reported prevalence in school age children of 4 per cent,[4] it was not surprising that 19 per cent of referred patients carried this diagnosis.

Diagnostic Evaluation

Diagnostic evaluation in our patients was determined by history, physical examination, and laboratory studies including appropriate biochemical, immunological, and radiographic tests. Serum creatinine, electrolytes, calcium, proteins and urine analysis often determined the extent and direction of further investigation. Immunologic studies were performed in cases of suspected glomerular disease. Some of these tests included complement profiles, antinuclear antibody, circulating immune complex titer, anti-glomerular basement membrane antibody determinations, anti DNA binding assay, and anti streptococcal enzyme titers. Selected radiographic

From the Department of Pediatrics and Medicine, Division of Renal Diseases, Rhode Island Hospital, and the Brown University Program in Medicine, Providence, Rhode Island.

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procedures were used to define abnormalities in renal structure and function. The intravenous pyelogram (IVP) visualized the upper urinary tract for evidence of hydronephrosis, urolithiasis, renal related hypertension, and maldevelopment. Voiding cystourethrograms provided a picture of the lower urinary tract when questions of ureteral reflux, urethral obstruction, or bladder dysfunction were raised. Sonography, like the IVP, was used to demonstrate renal size and position as well as the presence or absence of hydronephrosis and cysts.[5] Radioactive renal scanning provided anatomic as well as functional information in selected cases. Lastly, arteriography and venography of kidneys allowed for an accurate radiologic assessment in cases of suspected renal vascular hypertension.

Percutaneous or open renal biopsy added a new dimension in the diagnostic approach to children with renal disease. Immunologically mediated disorders such as systemic lupus erythematosis and various forms of nonsystemic glomerulonephr were studied and characterized in great det The techniques of electron microscopy a immunofluorescence expanded the pathologic formation supplied by light microscopy. Wh absolute indications vary with the institutio children who presented with lupus, unexplain non-orthostatic proteinuria with or witho hematuria, steriod resistant or depende nephrotic syndrome, or rapidly progressive re failure were usually biopsied (Table 2). The l nign nature of isolated hematuria with a negat evaluation and family history made biopsy for t condition unrewarding.[6] Results from t pathologic biopsy material often furnished bo therapeutic direction and prognostic information

Therapy

Treatment of chronic renal impairment involve team approach. Dietary consultation proved necessity in handling these children as problems

Table 1. Diagnosis of Renal Disease in Children Followed by the CDC Renal Clinic

Class	Type		Number	Percent
Glomerular	minimal change disease		11	
	mesangial proliferative glomerulonephritis		11	
	membranoproliferative glomerulonephritis		1	
	acute post streptococcal glomerulonephritis		3	
	focal segmental sclerosis		1	
	membranous nephropathy		1	
	Alport's syndrome		2	
	rapidly progressive glomerulonephritis (vasculitis)		1	
		TOTAL	32	46%
Hypoplastic - Dysplastic	with obstruction		8	
	without obstruction		3	
		TOTAL	11	16%
Metabolic	cystinosis		3	
	renal tubular acidosis		1	
		TOTAL	4	6%
Interstitial - Reflux		TOTAL	2	3%
Proteinuria (unclassified)		TOTAL	3	4%
Hematuria		TOTAL	13	19%
Cystic	medullary sponge kidney		1	
	infantile		1	
		TOTAL	2	3%
Hypertension	fibromuscular dysplasia		1	
	Laurence-Moon-Biedl		1	
		TOTAL	2	3%
	TOTAL		69	100%

caloric intake, electrolyte regulation, and protein and phosphate balance were frequently encountered. Most children required between 75 to 100 calories per kilogram per day for optimum growth potential. Supplemental sources of calories in the form of fats and glucose ploymers (Polycose®) were added to the diet as tolerated. A sodium restriction as low as 88 mEq per day was needed in cases of hypertension or edema forming states such as nephrotic syndrome. Avoidance of high potassium containing foods including oranges and bananas often was sufficient for children with modest renal impairment. However, as end-stage renal failure developed, further restriction in dietary potassium intake down to approximately 27 mEq per day was required to maintain the serum values below 6 mEq per liter. High biological value protein in the form of egg, meat, fish, or chicken was encouraged over cereal proteins. These high value protein sources are rich in essential amino acids and can be more completely utilized than can grain protein sources. Blood urea values over one hundred were controlled by high biological value protein diets and limitation of daily protein intake to 1 to 2 grams per kilogram. Phosphate balance was achieved in children with moderate to severe renal failure through decreased intake of milk and milk products.

Table 2. Indications for Renal Biopsy

1. Lupus erythematosis
2. Non-orthostatic proteinuria with or without hematuria
3. Steroid resistant or dependent nephrotic syndrome
4. Rapidly progressive renal failure

Pharmacologic advances provided another aspect of treatment. The judicious use of corticosteroids and cytotoxic agents such as chlorambucil and cyclophosphamide have been useful in certain types of nephrotic syndrome and collagen vascular disease. Calcium supplements were utilized in children with restricted milk intake in order to provide 700 to 1000 mg of elemental calcium per day. Synthetic forms of vitamin D such as dihydrotachysterol were prescribed in patients with moderate renal failure in order to maintain adequate gastrointestinal calcium absorption and bone mineralization. Unlike the endogenous sources of vitamin D, these drugs do not require the kidney for pharmacologic activity. Aluminum hydroxide gels in daily divided doses of 60 to 100 mg per kilogram were used to bind excess phosphate in the intestine thus controlling serum phosphate levels in children with limited kidney function.

Dialysis and Transplantation

Over the past nine years, the CDC Renal Clinic has managed 22 children under 18 years of age with end-stage disease. These figures have suggested an incidence of approximately 2.3 per million total population per annum, a number similar to the 0.85 to 2 per million reported from San Francisco, Minnesota, and other major centers.[7,8] Etiologies of end-stage failure were also quite comparable as depicted in Table 3. Glomerular diseases accounted for about half the cases in Rhode Island and elsewhere. Obstructive uropathies, renal hypoplasia, and hereditary disorders together were responsible for over a third of Rhode Island cases and cases pooled from other centers.

Regardless of the cause, medical, surgical, and nursing efforts have culminated in the care of these

Table 3. Causes of Chronic Renal Failure in Children (%)[7]

PLACE (Total Cases)	Mexico City (211)	Paris (270)	San Francisco (53)	Miami (81)	Rhode Island (22)	TOTAL (637)
Diagnosis						
Glomerulopathies	56	26	45	27	50	41
Obstructive uropathies	19	21	15	42	9	21
Renal hypoplasia	6	22	10	15	18	14
Hereditary disorders	5	23	13	2	9	11
Vascular nephropathies (mainly hemalytic-uremic syndrome)	1	4	4	6	5	4
Others	13	4	13	8	9	9

children for terminal renal failure. Ethical issues and marked growth retardation together with life threatening azotemia have underscored the need for aggressive intervention. With the difficulties inherent in the technical and psychological aspects of chronic dialysis and the limited growth potential in pediatric dialysis patients, renal transplantation has become, in most centers, the preferred treatment route for children with irreversible renal failure.[9,10]

Patients were referred to other major centers for renal transplantation, often while outpatient dialysis treatments were continued. Recipient evaluation included a urologic assessment to assure proper urinary drainage, HLA typing cytotoxic antibody profile, leukocyte crossmatch, blood typing, and in cases of a living related donor, mixed lymphocyte cultures. Children with obstructive uropathy were not excluded from possible transplantation. Every effort was made to reconstruct the lower urinary tract surgically to provide normal drainage. When this was impossible, a urinary conduit was created to accept the donor ureter. Following transplantation, five of the successful recipients returned to the clinic for followup. Maintenance immunosuppressive therapy consisted of azathioprine and prednisone in all our patients. As several centers performed the transplants, a definitive statement on success rate could not be made. On superficial examination of the thirteen children referred for either living related or cadaver renal transplant, eight were successful over one year (58 per cent) comparing favorably with other national pediatric statistics.[10,11]

Suitable donors, either cadaver or living related, were not available for all our patients with end-stage disease, thus dialysis was instituted as a temporizing measure. Indications for dialysis therapy (Table 4) included symptomatic azotemia (BUN usually over 150 mg/dl), electrolyte or acid-base imbalance, or both, and fluid overload. Of the five patients currently being dialyzed, two were begun on peritoneal dialysis and three on hemodialysis. Chronic peritoneal dialysis was achieved using a permanent indwelling catheter through the abdominal wall, developed by Tenckhoff and his associates.[12] Approximately forty hours per week divided into three treatments provided adequate clearance of waste products from the blood. Generally, dialysis was carried out at night with minimal discomfort as the child slept. One of the children was peritoneally dialyzed at home during the night using a newly developed automatic peritoneal fluid delivery system. The patient's parents had been previously trained in peritoneal dialysis techniques by hospital personnel. The other child, an infant, was admitted in the evening 3 times per week for peritoneal dialysis performed by the nursing staff to be discharged the next morning on completion of the treatment.

Table 4. Dialysis Indications

1. Symptomatic azotemia (BUN usually over 150 mg/dl)
2. Severe acidosis
3. Hyperkalemia
4. Fluid overload
5. Salt intoxication

Hemodialysis was performed on the other three patients utilizing a vascular access surgically created by anastomosing an artery with vein in one of the extremities. Four hours of hemodialysis three times per week allowed for adequate removal of waste products and fluid. All hemodialysis was done on an outpatient basis by the hospital staff with the children coming to the hospital after school for their treatments.

The main hemodialysis center for children in the state of Rhode Island has been located at the Rhode Island Hospital. Over the last 10 years, the center has performed acute or chronic hemodialysis on 26 children ranging in age from 3 to 18 years, including the three patients mentioned. The estimated costs of hemodialysis ran from $14,000 to $25,000 per year[13] in the United States with payment for all children arranged through third party insurers and Medicare.

In the management of children with renal disease, social service consultation proved a valuable asset. While much of the financial burden was offset by the Rhode Island Department of Health, Medicare, and third party providers, chronic illness created significant emotional burden. Individual and family counseling often provided the psychological and logistical support necessary to carry on with the complex medical treatments.

Summary

From the review of our own patient data, significant progress in the diagnosis and treatment of children with renal disease in Rhode Island has occurred. The impact of new diagnostics, diets, drugs, dialysis, and donor transplantation were felt in the community over the last decade. Only through a continued combined effort will these

medical advances reach our young patients and provide them hope for the future.

Acknowledgements

We thank Doctor Leo Stern for helpful comments during preparation of the manuscript, and Miss Charlene Viera provided secretarial assistance.

References

[1]Blackall J: Reports of medical cases, in Major RH (ed): Classic descriptions of disease. Baltimore, Charles C Thomas Publishers, 1932, p 491.

[2]Bright R: Guy's hospital reports 12:378, 1833.

[3]Schlesinger ER: The nephrotic syndrome. Amer J Dis Child 116:623-632, Dec 68.

[4]Dodge WF: Cost effectiveness of renal disease screening. Amer J Dis Child 131:1274-1282, Nov 77.

[5]Teele RL: Ultrasonography of the genitourinary tract in children. Radiol Clin North Am 15:109-128, Apr 77.

[6]West CD: Asymptomatic hematuria and proteinuria in children: Causes and appropriate diagnostic studies. J Pediatr 89:173-182, Aug 76.

[7]Zilleruelo G, Andia J, Gorman HM, et al: Main causes of chronic renal failure. Pediatric Nephrology 4:113,1978.

[8]Broyer M: Chronic renal failure, in Royer P (ed): Pediatric Nephrology. Philadelphia, WB Saunders, 1974, p 358.

[9]De Shazo CV, Simmons RL, Bernstein DM, et al: Results of renal transplantation in 100 children. Surgery 76:461-468, Sep 74.

[10]Fine RN, Malekzadeh MH, Pennisi AJ, et al: Long-term results of renal transplantation in children. Pediatrics 61:641-650, Apr 78.

[11]Krieger JN, Brem AS, Kaplan MR: Urinary tract infections in pediatric renal transplantation. Urology, to be published.

[12]Tenckhoff H. Schechter H: A bacteriologically safe peritoneal access device. Trans Amer Soc Artif Intern Organs 14:181-187, 1968.

[13]Manis T, Friedman EA: Dialytic therapy for irreversible uremia. N Engl J Med 301:1260-1265, 6 Dec 79.

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We like to think that the earliest volume in our Library is Pliny's Natural History *although the evidence for the date, 1501, is internal and the title page is missing. There is no question about our other sixteenth century texts. Two of them, Oribasius'* Collectorum Medicinalium . . . *and Galen's Galeni* Librorum . . . *were printed by the famous Aldine press and show the dolphin and anchor colophon on their title pages. There are other Galen items and Hippocrates and Galen as edited by Stephanus. Avicenna, Celsus, Fallopius, Fernel, Fracastorius, Gorraeus, Lycosthenes, Pare, Plater, the* Regimen Sanitatis Salerni *and Theodosius are all represented in our collection.*

From Helen E. De Jong, Librarian Emeritus

Hemochromatosis, Thrombocytopenic Purpura, and Multiple Endocrine Disturbances

An Unusual Association of Uncommon Disorders is Reported

Michael L. Friedland, MD
Paul Schaefer, MD

Hemochromatosis is the term for a clinical syndrome characterized by a disturbance in iron metabolism. It was described first by Trousseau[1] and later named "Bronzed Diabetes" by Marie.[2] Reviews by Sheldon[3], Finch[4], and Heilmeyer[5] further defined the association of excessive iron deposits in tissues, cirrhosis, and diabetes. This and other endocrine abnormalities including hypogonadism are found to occur in association with hemochromatosis in from 20 to 80 per cent of patients.[4,6] Iron deposition, often quite excessive, is present in many organs and is believed to contribute to the endocrine organ hypofunction described. The thyroid, one organ usually the site of rather heavy iron deposition, is rarely functionally deranged.[7] When thyroid function is affected, hypothyroidism often prevails. Williams[8] and Herford[9] each reported one case of hemochromatosis associated with hyperthyroidism. In our case, clinical hyperthyroidism was detected three years before the diagnosis of hemochromatosis was established.

Case Report

FM is a 56 year old white male who was first seen in August, 1970 for evaluation of weight loss, intermittent fever, and chest pain. He was found to have a left-sided empyema and pneumonia and was treated with closed chest tube drainage and antibiotics. This therapy resulted in the complete clearing of his pneumonia and his left-sided empyema. During his hospitalization he was found to have elevated thyroid function tests (T_4I-13.5 mcg%, normal 2.6-7.2 mcg%) total thyroxine — 16.1 mcg% (normal 4-11.2 mcg%). He was admitted four months later for gradual increasing shortness of breath and leg edema. During this admission he was again found to be hyperthyroid with a T_4I-13.5 mcg% (normal 2.6-7.2 mcg%), total thyroxine — 21 mcg% (normal 4-11.2 mcg%) and 24 hours I^{131} uptake of 75%. He was treated with oral I^{131}, 6 mc. At this time he was found to have an abnormal glucose tolerance test, ie F-120 mcg%, ½° - 248 mg%, 1° - 286 mg%, 2° - 238 mg%, 3° - 96 mg%. Liver function studies revealed an SGOT of 60 IU (normal 7-26 IU), LDH 120 IU (normal 40-100 IU), alkaline phosphatase 15.5 IU (normal 11-93 IU), SGPT 66 IU (normal 6-35 IU). He was thrombocytopenic with a platelet count of $5.5 \times 10^{10}/1$. His skin was hyperpigmented, and he complained of easy bruisability. His bone marrow showed many megakaryocytes, but none appeared to demonstrate platelet budding. His hemoglobin was 11.9 g/dl, and his white count was $3.0 \times 10^{9}/1$. He was started on 80 mg of prednisone, and his platelet count rose to $7.0 \times 10^{10}/1$ as the prednisone was tapered.

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He was lost to follow-up for nine months. When he returned, he was again clinically hyperthyroid with T_4-10.1 mcg%, total thyroxine — 15.5 mcg%, and he was retreated with an additional 5 mc of oral I^{131}. Prednisone administration was resumed. His platelet count did not rise from 1.5 - 1.7 x 10^{10}/l. This time he was seen in the Hematology Clinic, and the diagnosis of hemochromatosis was considered. Because his thrombocytopenia was minimally responsive to high doses of steroid, a splenectomy was performed. The spleen on pathological examination revealed excessive hemosiderin deposits. A liver biopsy, performed at the same time, also revealed increased hemosiderin deposits. Laboratory evaluation on readmission included a serum iron of 35.4 mmol/l total and an iron binding capacity of 42.2 mmol/l (83% saturation).

He failed to keep subsequent clinic appointments until June of 1976. Evaluation at that time demonstrated a palpable liver 3 cm below the right costal margin. Laboratory evaluation revealed the following: Hb - 13.3 g/dl, Hct - 40.0%, WBC - 5.8 x 10^9/l, platelet count - 2.7 x 10^{11}/l, serum iron of 44 mmol/l and an iron binding capacity of 48.2 mmol/l with 91% saturation, plasma cortisol level 22.2 mgm% (normal 18 mgm%), plasma testosterone 30 ng% (normal 300-1000 ng%) on two occasions, growth hormone 1 ng/ml (normal less than 8 ng/ml), $T_4$5.3 mcg% (normal 4-11.2 mcg%), $T_3$29.8 mcg% (normal 25-36 mcg%), TSH 4.2 I units/ml (normal 3.9±2.2 units/ml), FSH 2.3 MIU/ml (normal 5-25 MIU/ml), LH 9.6 MIU/ml (normal 6-30 MIU/ml), Vit. C 1.3 mg% (greater than .7 mg%), SGOT 56 IU (normal 8-31 IU), LDH 160 IU (normal 90-170 IU), SGPT 48 IU (normal 4-28 IU), alkaline phosphatase 222 IU (normal 32-85 IU). Currently the patient is undergoing weekly phlebotomies in an attempt to lower his total body iron content. He is clinically euthyroid, and physical examination reveals only mild hepatomegaly with a liver palpable 3 cm below the right costal margin and mild eunuchoid features.

Pathology

The liver biopsy showed diffuse nodularity with marked distortion of the lobular architecture. The liver tissue showed a striking increase in hemosiderin deposition, with hemosiderin found throughout the liver tissue, in cells lining the bile ducts, and within the fibrous tissue.

Discussion

Multiple endocrine abnormalities described in association with hemochromatosis have been primarily of a hypofunctional nature and have included hypothyroidism[10], hypoparathyroidism[11], hypogonadism[12], diabetes mellitus, and pituitary hypofunction[13]. In the case of hypopituitarism, Stocks and Martin[14] reported significantly depressed levels of leutinizing hormone (LH) and growth hormone (GH). Hypogonadism has also been observed with decreased testosterone levels bearing no relationship to LH levels[7]. Hyperfunction of endocrine organs has been noted and reported in two cases of hemochromatosis and hyperthyroidism.[8,9] Pawlotsky et al[15] recently reported on autonomous parathyroid hyperfunction in seven of twenty-seven cases of hemochromatosis. Simon et al[16] re-examined the question of pituitary functions and observed high levels of GH, follicle stimulating hormone (FSH), and LH. It has also been observed that the pituitary will respond normally to hormonal manipulation. No studies have been reported on melanocyte stimulating hormone (MSH) levels. However, the increased pigmentation seen in over 50 per cent of cases is not associated with excess iron deposition in the skin, but rather the result of an increased amount of melanin in the deeper layers of the epidermis.[17]

Many observers have attempted to relate the endocrine dysfunction to the toxic biochemical effects of excess tissue iron. Histologic examination of tissue demonstrate marked parenchymal iron deposits. This explanation is possibly satisfactory to explain examples of endocrine hypofunction, but does little to explain the relationships of organ hyperfunction.

Iron is ubiquitous and required for many biochemical activities. It serves as an oxidant in enzyme interactions including those involving endocrine organs. In hemochromatosis, one cofactor — ascorbic acid — is frequently found to be deficient. This vitamin in conjunction with iron is required in androgen metabolism.[19] It may also be involved in MSH and adrenocorticotrophic hormone (ACTH) production indirectly if the active end-product is not synthesized. This lack of negative feedback (melanin and androgens) may result in increased pituitary activity.

Iron is required for the deiodination of thyroid hormones.[19] While not a major pathway in T3 and T4 metabolism, small increases in thyroid hormone synthesis may result (in states of iron excess). In an individual with already depressed metabolic functions, this may produce increased thyroid activity.

Gonadal dysfunction as evidenced by decreased testosterone production is well documented. When

LH levels are studied in patients who are stimulated with clomiphene, some of them are capable of responding in a normal fashion irrespective of androgen levels.[7] This apparent feedback defect may be explained by a false messenger, or end-product, although to date no data are available to support this proposal.

More likely, the endocrine organ abnormalities observed are related to several factors. These include hereditary abnormalities (suggested by the association of diabetes mellitus in family members of patients with hemochromatosis[20,21]), hypothalamic pituitary dysfunction, end-organ dysfunction with either increased or decreased sensitivity to pituitary trophic hormones, or the presence of production of false feedback signals (such as the case in hypogonadism). Our case serves to demonstrate the variable endocrine manifestation of this interesting disorder.

The unusual association of thrombocytopenic purpura responsive to splenectomy in this patient with hyperthyroidism and hemachromatosis is noteworthy, but a general mechanism inducing all three of these syndromes is not apparent.

References

[1]Trousseau A: Glycosurie: Diabete Sucre, Clinique Medicale de l'Hotel-Dieu de Paris, ed 2. Paris, JB Bailliere, 1865, vol 2.

[2]Marie P: Sur un cas de diabete bronze suivi d'autopse. Semaine med, Par 15:229-232, 1895.

[3]Sheldon JH: Haemochromatosis. London, Oxford University Press, 1935.

[4]Finch SC, Finch CA: Idiopathic hemochromatosis, an iron storage disease: Iron metabolism in hemochromatosis. Medicine 34:381-430, Dec 55.

[5]Heilmeyer L: Pathogenesis of hemochromatosis. Medicine 46:209-215, Mar 67.

[6]Bricaire H, Guillon J, Depart T, Modigliani, Kourilsky B: Le syndrome endocrinien des hemochromatosis idiopathique (a propos de 88 observations). Bul Soc Med Hop, Par 117:909, 1966.

[7]Jacobs A, Worwood M (eds): Iron in Biochemistry and Medicine. New York, Academic Press, 1974.

[8]Williams RS: Increased thyroid function in haemochromatosis. Brit Med J 1:1078-1080, 25 Apr 59.

[9]Herford ME: Haemochromatosis, diabetes, and hyperthyroidism letter. Brit Med J 3:359, 9 Aug 69.

[10]McAllen PM, Coghill NF, Lubran M: The treatment of haemochromatosis with particular reference to the removal of iron from the body by repeated venesection. Q J Med 26:251-276, Apr 57.

[11]Seze S de, Solnica J, Mitrovic D, et al: Joint and bone disorders and hypoparathyroidism in hemochromatosis. Semin Arthritis Rheum 2:71-94, Summer 72.

[12]Williams R: Haemochromatosis, in Bouchier IA (ed): Symposium on Advanced Medicine, 7th Proceedings. Baltimore, Williams & Wilkins, 1972.

[13]Stocks AE, Mattin FI: Pituitary function in haemochromatosis. Amer J Med 45:839-845, Dec 68.

[14]Stocks AE, Powell LW: Pituitary function in idiopathic haemochromatosis and cirrhosis of the liver. Lancet 2:298-300, 12 Aug 72.

[15]Pawlotsky Y, Roussey M, Hany Y, et al: Hyperparathormonenia and idiopathic hemochromatosis. Nouv Presse Med 3:1757-1758, 20-27 Jul 74.

[16]Simon M, Franchimont P, Murie N, et al: Study of somatotropic and gonadotropic pituitary function in idiopathic hemochromatosis. Eur J Clin Invest 2:284-289, Nov 72.

[17]Cawley EP, Hsu YT, Wood BT: Hemochromatosis and the skin. Arch Dem 100:1-6, Jul 69.

[18]Wapnick AA, Lynch SR, Krawitz P: Effects of iron overload on ascorbic acid metabolism. Brit Med J 3:704-707, 21 Sep 68.

[19]White A, Handler P, Smith EL: Principles of Biochemistry, rev ed. New York, McGraw-Hill, 1973.

[20]Goossens JP: Idiopathic haemochromatosis: Juvenile and familial type — endocrine aspects. Neth J Med 18:161-169, 1975.

[21]Wistran DC, Georas CS: Idiopathic hemochromatosis, long term treatment and hepatoma: A case report and review of the literature. RI Med J 60:65-77, Feb 77.

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One Sentence Essay

One of the bedrock tenets of professordom is that you can't amount to much if you pay for your own tickets.

. . . Daniel Greenberg, Washington correspondent of *The New England Journal of Medicine,* commenting on the travels of "jet-set professors".

Cigarette Smoking by Rhode Island Physicians: A Fifteen Year Update

Percentage of Physicians Who Smoke Continues to Decrease

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John T. Tierney, MSW
Pasco DePalo, BS

The role of physicians as both adviser and potential exemplar in matters of health behavior has produced continuing interest in their patterns of smoking, and studies, both in this country and abroad, have consistently shown that doctors smoke less than their lay counterparts. Longitudinal studies, including our own[1-3], have also shown a marked and continuing drop in the proportion who still smoke cigarettes. The matter has received sufficient attention in medical literature to require little additional comment, but there is some need for further following of the time trends. The present paper, a combined effort of the Rhode Island Medical Society and the Department of Health, extends earlier observations to cover the fifteen years which have passed since our first study, which preceded by a few weeks the landmark report of the Surgeon General in 1964.

Exhaustive and current bibliographies are available, particularly in the Surgeon General's latest report for 1979[4], and will not be repeated here. We shall look briefly at those limited questions which have led us to re-survey the practitioners of Rhode Island. We had wondered, for example, whether the medical profession, already including so few users of cigarettes, would begin to show a flattening of the curve, with a slowing of its rate of fall. We wondered, too, why so many physicians appear never to have smoked regularly. The existence of rather prominent smoking differences between US physicians and those in other countries led us to wonder whether the foreign-trained would differ from domestic graduates. We have for the most part confined our objectives to these points.

Method

In September of 1978 a letter, signed jointly by the Director of Health and the President of the Rhode Island Medical Society, was sent to all physicians thought to be active practitioners residing in Rhode Island. A copy of the reprint of the 1973 study was enclosed, and attention was directed to the forthcoming study, recommending response. About two weeks later, a questionnaire designed to be comparable with those used previously was enclosed with the forms for annual license renewal. The questions merely asked about current or former cigarette smoking, the use of other forms of

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tobacco, and current specialty or field of practice. Age, sex and school of graduation were already in our records and were not asked. Osteopathic physicians, a small group, were not included since they had not been involved in the earlier studies. As in previous studies, it was assumed that asking whether the individual had been a "regular" smoker discriminated better as to significant cigarette use than would an arbitrary quantitative dividing line.

About six weeks later, a follow-up letter with a duplicate questionnaire, stamped "second request", was mailed out to all of those who had returned their license registration forms without responding, but not to those who had not re-registered. This latter group, since it remained unclear as to whether or not they remained active in practice, were included among the non-respondents. Thirty physicians were found to have died, retired, or left the state and were dropped from the study.

Results

We have previously commented on the bias which results from the less willing response of smokers to such a mail survey as this[5]. The initial mailing brought in responses from 77.2 per cent of those questioned (1289 individuals), and 11.1 per cent of these were current cigarette smokers. An additional 6.6 per cent (110 individuals) who responded to the second mailing included 30.9 per cent who were cigarette smokers. The overall response was thus 83.8 per cent, slightly lower than the surveys five and ten years earlier.

The findings in the entire group of 1399 respondents out of the total of 1669 are summarized in Figure 1.

The initial suspicion that the curve representing current smokers would begin to flatten was not borne out. The low rate of 12.7 per cent who smoke cigarettes results from the fact that the shrinking group that have ever smoked have attained a high rate of quitting, and there has been an influx of individuals who indicate that they have never been "regular" smokers. These latter are mostly younger individuals. For example, the 53 who were under 30 years of age included 80 per cent who had never smoked (and an additional 11 per cent who had quit).

Sixty-two women physicians responded, and averaged a full ten years younger than the men. Among the 31 who were under 40 years of age, 9.7 per cent smoked cigarettes, while the men in the same age bracket showed 10.9 per cent. The small number of women and their minor difference in

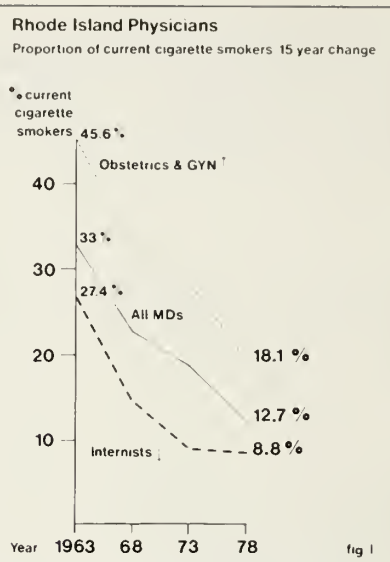

Figure 1. Changes in Percentages of Cigarette Smokers Among Rhode Island Physicians, 1963-1978.

smoking did not warrant their separation from the group as a whole.

Some of the changes by specialty are displayed in Table 1. Not all of the individual five-year changes are statistically significant — but the overall trends are sufficiently consistent to be of interest.

Only two groups have shown an increased rate of cigarette smoking (not statistically significant) over the past five years, the anesthesiologists and the otolaryngologists, while the orthopedists have shown a particularly steep decrease. We are unhappy to find that the obstetrics-gynecology group, with its high potential for influencing the behavior of young parents, still occupies the highest position, but a very small margin. Pediatricians have shown a drop in rate. We can offer no confident explanation of these differences.

Slightly less than one third of our respondents were graduates of schools outside the US and Canada, and their proportion of current cigarette smokers was identical with the rest, but those not reporting current cigarette smoking included more former smokers. Only 6.1 per cent smoked other forms of tobacco, as compared to 11.3 per cent of those with domestic training.

Table 2 shows those changes which were identified in the 858 physicians who had responded in both the 1973 and 1978 survey. About one of every five who had reported cigarette smoking at the earlier survey had quit in the succeeding five years, and only about one in twenty of the former smokers of the 1973 survey had resumed the prac-

Table 1. Proportion of Respondents Reporting Current Cigarette Smoking — Four Studies

Specialty*	1963 %	1968 %	1973 %	1978 %	1978 Number	Change Since 1963 %
Internal Medicine & Subspecialties	27.4	15.2	9.2	8.8	352	-67.9
General and Family Practice	34.5	21.5	17.2	12.6	167	-63.5
Surgery	32.0	25.4	25.3	14.0	164	-56.3
Psychiatry	35.7	25.9	20.7	17.1	111	-52.1
Pediatrics	23.3	16.7	20.7	10.1	119	-56.7
Obstetrics and Gynecology	45.6	32.3	28.1	19.1	94	-58.1
Radiology	22.2	23.3	16.1	14.9	67	-32.9
Orthopedic Surgery	40.7	29.0	19.0	9.4	64	-76.9
Anesthesiology	35.5	31.8	14.0	17.5	57	-50.7
Pathology	25.0	20.7	18.0	12.2	49	-51.2
Otolaryngology	25.0	25.0	16.7	19.2	26	-23.2
All respondents	33.0	22.6	19.0	12.7	1399	-61.5

*Specialties represented by 20 or more respondents.

Table 2. Smoking Status of 1978 Respondents in 1973

Status	Number	Percent
Smoking Cigarettes in 1973	(150)	
1978 Continued	91	60.7%
Stopped	59	39.3%
Former Cigarette Smoker in 1973	(320)	
1978 Still not smoking	303	94.7%
Resumed smoking	17	5.3%
"Never smoked cigarettes" in 1973	(388)	
1978 Still not smoking	386	99.5%
Started smoking	2	0.5%
Total Responding in Both Studies	858	

tice. Nearly all of the 388 who claimed never to have been regular smokers in 1973 admitted to an occasional cigarette in 1978, but none reported commencing to smoke regularly.

Discussion

In Rhode Island at least, there is evidence that the rate of cigarette smoking by physicians is falling at least as rapidly as before. If this rate of change were typical of the country's physicians generally, it would mean a drop of about 45,000 in the number of cigarette users. We find no difference between foreign and domestically trained physicians, and none among women as compared to men that cannot be attributed to age.

One can theorize about the differences among the specialties, but in the absence of any direct evidence, this remains a field for speculation.

The high proportion claiming never to have been regular smokers of cigarettes is interesting. We, among others, have pointed out that non-smoking must have preceded by several years any exposure to formal medical education. Marshall[6] has found evidence that only some 15 per cent of fourth year medical students, as is true of our physicians under age 30, are current smokers. Are they reflecting characteristics of the population from which they tend to have been derived, as many have suggested? We wonder, however, whether teenagers who are aiming towards medicine may have already begun to be influenced by the role of the physician as they visualize it.

In any event, one can allow oneself to hope that the low rates characterizing this professional group may presage, or help to produce similar patterns among others in the future.

References

[1]Murphy TH, Tierney JT: Current status of cigarette smoking among Rhode Island physicians: RI Med J 46:655-657, Dec 63.

[2]Burgess AM, Tierney JT: Rhode Island physicians' smoking habits revisited 1963-1968: RI Med J 52:437-440, Aug 69.

[3]Burgess AM, Casey DB, Tierney JT: Cigarette smoking by Rhode Island physicians 1963-1973: Comparison with lawyers and other adult males: Amer J Public Health 68:63-65, Jan 78.

[4]Smoking and Health: A Report of the Surgeon General. US Department of Health, Education and Welfare, Public Health Service, Office on Smoking and Health, 1979, pt 3, ch 22, pp 1-28.

[5]Burgess AM, Tierney JT: Bias due to nonresponse in a mail survey of Rhode Island physicians' smoking habits — 1968: New Eng J Med 282:908, 16 Apr 70.

[6]Marshall RJ: Smoking in Rhode Island. RI Med J 62:215-223, Jun 79.

[7]Birkner FE, Kunze M: Smoking patterns at a British and at an American school: Med Educ 12:128-132, Mar 78.

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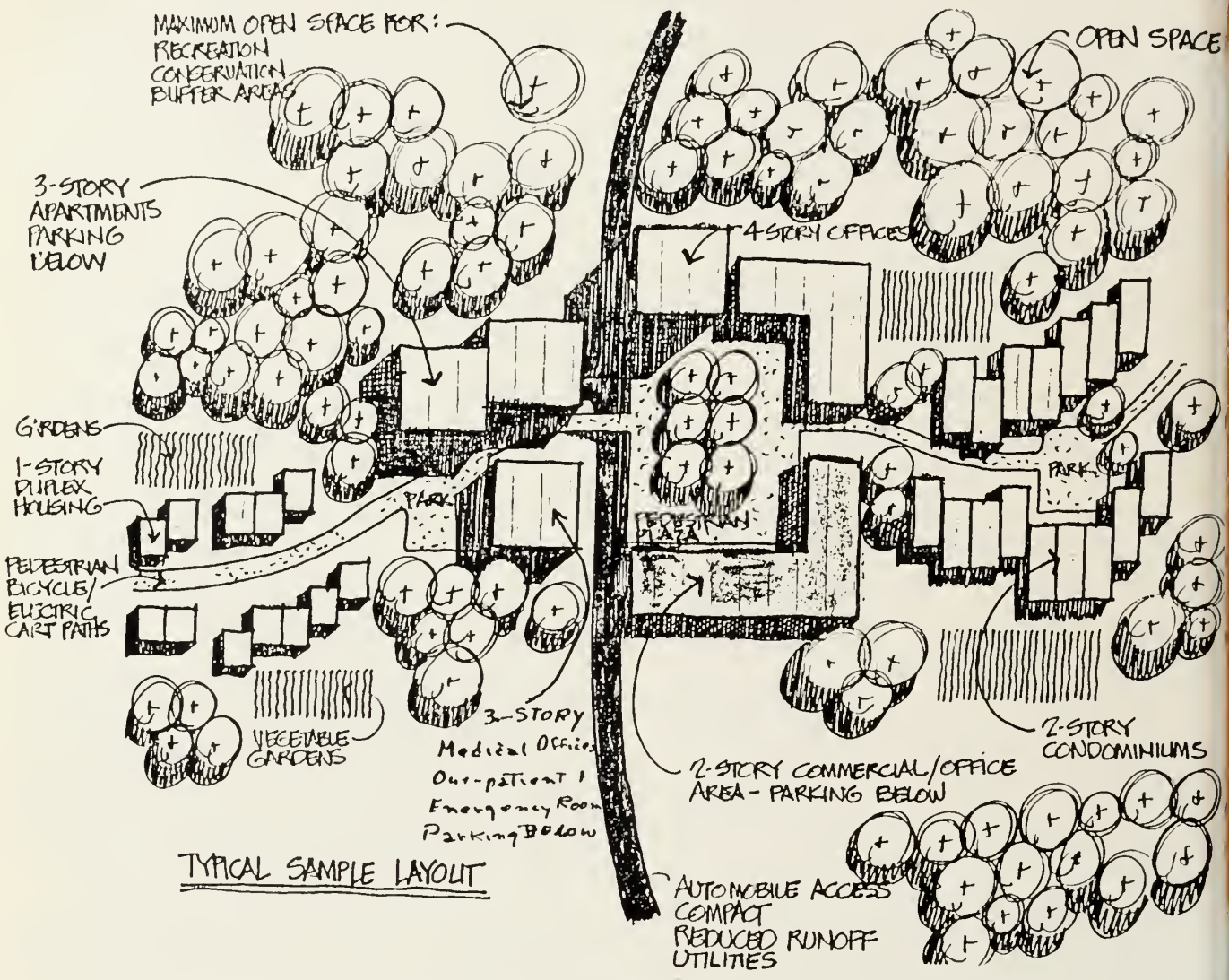

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Structures in the design will include in-patient and out-patient facilities situated strategically accordi to the needs of the total community, which will be limited as to size and population to prevent urban spra and protected by natural buffer areas to prevent encroachment by neighboring developments.

An actual site plan with specifications and at least two specific sites in Rhode Island will be the result the project, using the professional skills of architects, engineers, attorneys, bankers, contractors, business and physicians. The project has the full support of the Office of the Governor of the State, which is providi $25,000 in services to the project.

The project is underway and one site is already under consideration. However, funding is still sho and contributions would be gratefully appreciated. For more information, contact:

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October 1980
Volume 63, Number 10

Rhode Island Medical Journal

S Council Raises Flags *See Newsletter*

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Anaphylactic Reactions in Asthmatic Patients

The Use of the Celestin Tube in Complicated Esophageal Problems

Current Status of Cardiac Pacing

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3. Frequency of issue: *Monthly*
4. Location of known office of publication: 106 Francis St., Providence County, Rhode Island 02903
5. Location of headquarters or general business offices of the publishers: 106 Francis St., Providence, R.I. 02903
6. Names and addresses of publisher, editor and managing editor:
   Publisher: Rhode Island Medical Society, 106 Francis St., Providence, R.I. 02903
   Editor: Seebert J. Goldowsky, 458 Wayland Ave., Providence, R.I. 02906
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7. *Owner:* Rhode Island Medical Society, 106 Francis St., Providence, R.I. 02903
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October 1980
Volume 63, Number 10

Rhode Island Medical Journal

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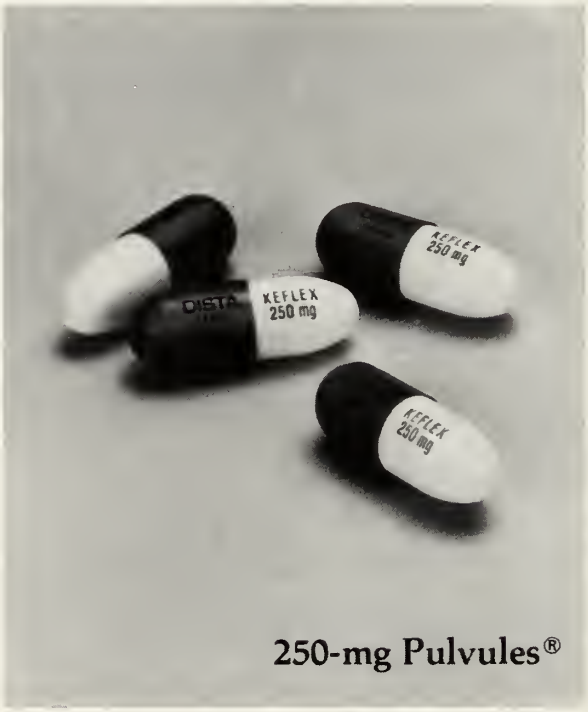

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)de Island Medical Society

October 1980

lewsletter

Peter L. Mathieu, Jr., MD, Editor
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'he Boomerang of Rising Nursing Home Costs

narles E. Millard, MD* and Ursala Beauregard, RN

ne of the most significant phenomena affecting merican industry over the last 100 years has been the owth of public regulation. What started out as a few gulations has now grown to an unbelievable extent. e passion for regulation for much of this century s extended to all aspects of medicine. All of medical re delivery is in the grip of regulation. From a rea- nable control of medical licensure by the various ates, federal regulation has been moving into the lection of medical students, supervision of medical hools, control over specialties, and even antitrust idictments. Control over the manufacture of drugs s steadily advanced to control of therapeutic usage drugs. Hospitals are currently under supervision by merous committees mandated by federal and state gulations.

The multiplication of regulatory procedures has in- eased the cost of medical care to an extent which is w becoming appreciated by critics of the medical ene. A survey performed and reported in New York tate found that hospitals were ruled by no fewer an 164 regulatory agencies, including 40 at the deral level. The costs inflicted by these agencies nounted to 25 percent of the total hospital budgets, a statewide average of $38.66 per patient day. The sts will continue to rise as the Department of Health d Human Services (DHHS) continues to promulgate m *650* to *750* new or revised regulations affecting spitals each year.

The unorganized and fragmented nature of many vernment regulatory problems is a factor which ds to the escalating cost of health care. Repetitive rveys which duplicate and in many cases triplicate a ocess are wasteful, confusing, and add nothing to tient care. In fact, in many instances they detract m this care. A new nursing home in Rhode Island ith 120 beds and costing $3 million, after thirty-six nths of planning, building, and administrative ocessing by appropriate public agencies, opened rly in 1977. In 1978, the first complete year following e opening of this facility, inspections were made hich took a total of *989¼* hours.

The spending of numerous hours by personnel to hieve paper compliance is not cost efficient or fective and contributes nothing to the nursing me's most important function — the providing of ality patient care.

Rules and regulations are obviously necessary to maintain high standards of operation and care of the patient; and many government review processes, such as those carried out by Rhode Island Professional Standards Review Organization (PSRO), bring about significant cost savings. However, when numbers of forms required by various federal, state, PSRO, and other agencies are for all intents and purposes identical, something should be done.

For those facilities which are obviously in excellent compliance, I suggest a yearly certificate be awarded similar to the certificate granted by the Joint Committee on Accreditation of Hospitals. This would allow more time to inspect those institutions which are operating marginally and are not in compliance. Medical review teams could be reassigned to problem areas, thus using time and talents to improve the system and elevate standards of care for our patients.

The money saved by reduction of paper work could be returned to nursing homes for the training of nurses aides. Such personnel are often woefully ill-prepared, and should have more education in dealing with the aged. What a wise move it would be to trade useless paper compliance for real practical improvements.

ember of the American Medical Association

RIMS • Membership Count • RIMS
(as of August 31, 1980)

Total RIMS members	1355
Total AMA members	809
New RIMS members (since June 30, 1980)	10

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Marguerite Vigliani (student)

Cover photo: Flag raising depicts the completion of an idea initiated by Joseph E. Caruolo, MD* during his term as President. See next page for close-up photo of Council with names.

Council Briefs

- Heard a presentation by Mr. Carl Hofferberth and Mr. John Tudor of I.C. System, Inc. of St. Paul Minnesota on an association-sponsored collection service. A motion was approved to withhold a decision on Rhode Island Medical Society involvement until the next Council meeting.

- Heard a report by Kenneth Liffmann, MD, on the Society's options for Major Medical, Delta Dental, and liability (JUA) and excess liability insurance.

- Heard a report of the Publications Committee and approved its proposed budgets for 1980 and 1981. It was noted that there may be some increases in the 1981 budget.

Council members and guests: Row 1 (left to right), Herbert F. Hager, MD,* Peter L. Mathieu, Jr., MD,* Joseph E. Caruolo, MD,* Melvin D. Hoffman, MD;* Row 2 (left to right), James A. McGrath, MD, Seebert J. Goldowsky, MD,* Peter D.T. Clarisse, MD,* Daniel Moore, Jr., MD,* Richard G. Bertini, MD;* Row 3 (left to right), Paul J.M. Healey, MD,* Paul B. Metcalf, Jr., MD,* Richard L. Testa, MD,* Howard E. Lawton, Charles L. Hill, MD,* Charles Clapp, Esq.

- Heard a report by Melvin D. Hoffman, MD* on negotiations conference that he attended in June, a approved a motion to involve specialty societies in activities of the Rhode Island Medical Society Negotions Committee.

- Discussed Rhode Island Medical Society effo to increase membership and the need for widespre cooperation in this activity.

- Heard a summary report of the Managem Committee stating that applications for the position Executive Director have been narrowed to abo twenty candidates, from whom the Committee select three for the Council's consideration.

- Approved the President's appointments of de gates to the meeting of the Council of the N England State Medical Societies on October 11, 19 Rhode Island Medical Society representatives will Drs. Peter L. Mathieu, Jr.,* Paul B. Metcalf, J Charles E. Millard,* John J. Cunningham,* Herbert Hager,* David Hallmann,* and staff.

- Heard reports of John Cunningham, MD,* De gate and Herbert F. Hager, MD,* Alternate Delegate the AMA House of Delegates Annual Meeting in C cago, July 20 - 24.

- Heard a report from Charles E. Millard, MD,* Rhode Island Department of Health Appropriatene Review procedures and other current matters of Delivery of Medical Care Committee.

- Heard and approved a Report of the Treasu Erminio Cardi, MD.

- Approved the appointment of Milton W. Han sky, MD,* as Trustee-at-Large on the Board of Trust of the RIMS Library Building for a one year term.

- Heard a report by David Hallmann, MD* on status of the Cooper Property.

SPARI Notes . . .

Roger Williams General Hospital was the setting for a meeting on September 8th of staff presidents of Rhode Island hospitals, who comprise the Staff Physicians Association of Rhode Island (SPARI). Hospital bylaws; liaison with Rhode Island Blue Cross/Blue Shield; the sharing of liability insurance expense among hospitals; and positions with relation to state health planning processes were the principal agenda items.

Dr. Joan Abar is developing a central repository for bylaws of hospitals in Rhode Island. When the project is complete, the file will be an association resource. For example, by consulting the file a hospital will be able to discover glaring inadequacies or omissions in its bylaws.

Dr. Richard Judkins* presented to the association a document which reports on more than a year's work to improve relationships between Blue Cross/Blue Shield and the state's physicians. Many problems have been addressed. For example, all participating physici now receive revised rate schedules before they h been effected. Also, new participating physicians receive more comprehensive profile information. Ot improvements are planned.

Dr. P. Joseph Pesare* gave an update report shared liability insurance expense between hospit Interest in this is variable between hospitals. The n step in the project is the development of an infor tional packet on the subject to be distributed to ho tals with the offer of SPARI assistance.

Dr. Peter L. Mathieu, Jr.* and **Dr. Erminio Cardi** ported on recent Rhode Island Medical Society cussions with the Rhode Island Department of He on planning and regulation issues. Dr. Cardi asked the association's endorsement of resolutions to Department of Health concerning its handling hospitals' applications to expand facilities. A res tion objecting to these procedures will be forwar immediately to the Department of Health.

nterview of the Month:

. Joseph Pesare, DrPH, MD

sense of organization, well-developed administrative ills — combined with commitment, ideals, and a rpose — are a surefire combination. Dr. Pesare's rpose has long been good medical care and high alth standards; his administrative abilities have ought to realization a number of programs recog-ed as national models.

Dr. Pesare developed a Home Care Program in ashington, DC in 1949, the first in the country de-ned exclusively for the cancer patient. It offered a l range of supports — medical, nursing, psycho-ical, and social — in a home setting, at reasonable st, with encouragement to comforts the patient es not have in an institution.

The hard work of planning and administrating, Dr. sare believes, has to be undertaken by both the blic and the private sectors, and, best of all, in operation with each other. Policy decisions made at top are implemented in programs which, in turn, ect future decisions. Unsuccessful implementation precipitate future undesirable policy. A task done ll today obviates the need for supplementary pro-ions to fill in for what fell between the cracks.

n medicine today, Dr. Pesare believes, it is espe-lly important that physicians guard against acquies-nce by *stubborn negativism*, which will cause them lose by *default* the opportunity to participate in lding programs. Both federal and state projects y require local physician input on all kinds of tters; and physicians *must* step forward to partici-te.

Dr. Pesare earned MPH and DrPH degrees at Massa-usetts Institute of Technology, and an MD degree, *m laude*, from Georgetown University. Author of veral publications, special reports, and numerous jor talks on public medical care, Dr. Pesare has also rked in education. His doctoral thesis entailed a dy of community health service awareness in junior d senior high schools in Rhode Island and at Rhode and College (RIC), then Rhode Island College of ucation (RICE). Later at Georgetown University, ere he did his own medical studies, he developed a gram for teaching hygiene and public health to dical students. He continued at Georgetown Uni-sity beyond graduation in a part-time capacity, rving simultaneously in the regular corps of the ited State Public Health Service, to become Asso-te Professor and Director of the Department of eventive Medicine and Public Health there, and to velop a new type of public health teaching program ich stressed cooperation of physicians, nurses, cial workers, and other professionals to achieve ucational goals. In subsequent years, the ap-baches he expounded came to be widely held and cepted around the country.

In 1952, Governor Dennis J. Roberts and Mr. Edward Reidy, then director of the Department of Social lfare, asked him to organize the Rhode Island dical Assistance Program. Initially, this undertaking tailed visiting and talking to professional associa-

tions and other groups, teaching and encouraging them, learning their concerns, and working out the adjustments necessary to satisfy both providers and consumers who would be affected by the program.

Dr. Pesare is very appreciative of the support of the Rhode Island Medical Society and especially the Committee on Social Welfare and all the physicians in Rhode Island for their understanding and willingness to work with him and the Governor and legislative body to make the Title XIX welfare medical care program in Rhode Island the best in the country. As Director of Medical Services, Rhode Island Department of Social and Rehabilitative Services, Dr. Pesare admits pride in the Rhode Island Medical Assistance Program as it exists today. The state ranks number one in the nation for liberality of eligibility standards, and has approximately 86,000 participants. The program maintains budgetary solvency, and has not found it necessary at any time to either curtail services or to pro-rate or reduce a fee schedule once established.

Dr. Pesare now holds a clinical assistant professorship in medicine at Brown University, continuing teaching interests of earlier years. When he came back to Rhode Island in 1951, he left the academic environment. He brought with him, however, the daughter of one of his professors at Georgetown University, his wife, the former Nina Mollari. Dr. and Mrs. Pesare have a son, who graduated from Providence College, and now works in administration at Roger Williams General Hospital; and a daughter, who graduated from the Boston University School of Fine Arts, and now aspires to achievements in New York theatre. Dr. and Mrs. Pesare's home is in Providence, not too distant from Providence College, the Doctor's alma mater. ■

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Administrative Reports . . . Meetings with Officers and Sta

Wednesday, August 13, 1980 . . . discussed ways for the Rhode Island Medical Society to coordinate medical and related services in underserved areas, in cooperation with the Rhode Island Department of Health . . . Dr. Charles L. Hill stressed the importance of a full scale effort by the Rhode Island Medical Society to obtain its own statewide manpower data . . . decided on a RIMS position opposing the designation of Central Falls as a manpower shortage area . . . Dr. Hill stressed the importance of identifying residual groups which do not take advantage of medical care even when it is available . . . discussed RIMS position for presentation at the Joint Underwriting Association (JUA) rate filing hearing on August 20 . . . heard reports of the Blue Shield Liaison, Management and Insurance Committees . . . discussed importance of Rhode Island Medical Society coordination of quality review activities and assigned Karen Challberg to develop some administrative guidelines . . . reviewed miscellaneous Society correspondence and business matters.

Wednesday, August 20, 1980 . . . discussed RIMS position on the 25.3 percent increase filed for by the Joint Underwriting Association (JUA) . . . discussed the importance of education on existing malpractice claims and the need for strengthening by the JUA of its risk management education programs . . . considered the desirability of retaining an actuary on a continuous basis to become experienced in JUA and related problems . . . Dr. Metcalf reported that a position paper on "medically underserved" designations prepared by him (see page 363) had been distributed to Drs. Hill, Millard, and Mathieu for review . . . heard and discussed a report by Karen Challberg on ways to generate input to the Rhode Island Department of Health Appropriateness Review process . . . Dr. Mathieu assigned Karen Challberg to present a written paper on Rhode Island Medical Society internal organization relating to this process at the next business meeting . . . reviewed miscellaneous Society correspondence and business matters.

Wednesday, August 27, 1980 . . . guest Dr. Seebert J. Goldowsky* explained the State Medical Journal Advertising Bureau (SMJAB) and its functions . . . guest Dr. Dario A. Herrera* presented a plan for the organization of an exercise physiology clinic . . . his ideas were enthusiastically endorsed . . . Dr. Millard presented evidence on the cost in time utilized to obtain compliance with state regulations in the nursing home industry . . . discussed a RIMS position on SHCC Regional Committees . . . Dr. Metcalf was assigned to present the Society's position in brief to the upcoming meeting of the Statewide Health Coordinating Council (SHCC) . . . discussed ways of involving district societies in RIMS affairs . . . reviewed miscellaneous Society correspondence and business matters.

Wednesday, September 3, 1980 . . . guests of the meeting were Rhode Island Department of Health staff members William J. Waters, PhD, Assistant Director — Health Policy; and Donald C. Williar Supervising Health Planner . . . discussions identif the problems of 1) identifying and providing for truly underserved in areas so designated; 2) identify primary care services available in an area, but recognized as such; and 3) educating populatic about services available in their areas . . . discuss the role of the physician in addressing the above pr lems . . . agreement was confirmed between RIMS a the RI Department of Health to work together in collection of manpower data . . . Dr. Mathieu assigr representatives to an upcoming meeting of the Vol tary Committee of Health Providers (VCHP) . . . Mathieu will present a charge to the Liaison Cc mittee with Brown University to open discussions w the medical school on this matter . . . reviewed m cellaneous Society correspondence and busine matters.

Dr. Mathieu greets Dr. William Waters.

Peripatetics

Donald S. Gann, MD, Chief of Surgery at Rhode Isla Hospital, has been appointed the J. Murray Beards Professor of the Section of Surgery at Brown U versity.

Richard E. Land, MD* has been selected for Fellc ship in the American College of Radiology.

New officers of the Notre Dame Hospital medical st are **Paul B. Metcalf, Jr., MD,*** President; **George Noble, MD,*** Vice President; **Stephen T. Conway, MI** Secretary/Treasurer; **Juan N. Medina, MD,*** Chief Surgery; **Jaroslaw Koropey, MD,** Chief of Medici **Bert S. Jeremiah, MD** and **John M. Thorp, MD** w elected members of the Executive Committee.

Position Paper on "Medically Underserved" Designations

Prepared by Paul B. Metcalf, Jr., MD*

The Rhode Island Medical Society (RIMS) welcomes the opportunity afforded it by the Rhode Island Department of Health to put its knowledge and expertise to cooperative and constructive use in achieving common community goals. Our remarks will define in our terms those goals, will critically but constructively examine the present methodology, and make positive suggestions for solution of what we perceive to be current problems.

We feel that in such a presentation as this it is wise at the outset to examine the pertinent philosophical approaches to the given problem, as held by the public health sector, as well as those held by the private sector of medicine. The specific purposes are those of identifying not only areas of divergence, but more importantly areas of convergence of thought.

Superficially it may appear that the two sectors have more differences than points of similarity. For example, private physicians (and the various associations of such) tend to view most issues from the point of view of the single, individual person who happens at that moment to be (or who may in the future become) a *patient* (ie, one who is ill, injured, or parturient). The public sector tends to regard such issues in the *aggregate*, and more from a preventive than a therapeutic or palliative approach. It could be said with fair accuracy that the physician looks at the world as it is, and the public health practitioner looks at the world as it could or should be. Further, we look at ourselves as *patient* advocates (recalling that the patient *is* ill, injured, or parturient and requires medical services) while you regard yourselves as advocates of the *public* (who *may* or *hopefully may not* require medical services).

There is, however, a commonalty of approach to the subject issue, in that both groups agree without substantive difference that each individual has a right to medical attention when it is needed, and each such individual has a positive concomitant obligation to do all in his power and knowledge to avoid predictable risks to his health. (There is no inherent right without complementary inherent and equal obligation).

Given these convergences of philosophy at this point, ie, that broadly speaking there *should be no* "medically underserved areas", and having the further concurrence that an excess of physicians is at the least undesirable, we should see if we can reach a common definition of the issues and problems at hand.

The present situation is that under federal statute, and based upon recommendations in the past from the Rhode Island Department of Health, seven areas of Rhode Island have been designated by the Department of Health and Human Services (DHHS), formerly the Department of Health, Education, and Welfare (DHEW) as having shortages of primary medical care manpower (ie, General/Family Practice, Internal Medicine (general), Pediatrics (general), and Obstetrics/Gynecology). Such a designation allows entities to apply for federal assistance including manpower, grants, and low-cost loans. The basic criteria for such a designation depend upon a determination of a ratio of resident population to Full Time Equivalent (FTE) "primary care physicians" which exceeds 3500:1. There are additional qualifying secondary criteria, applicable in the main to entities with special circumstances.

Hence, under most conditions, the designation process requires three main types of information: 1. a reasonable estimate of the population; 2. a count of "primary care physicians" located either primarily or secondarily in the area (and their training status, since in general residents/trainees are accorded but 50 percent full time equivalency); and 3. some acceptable measure of the Full Time Equivalency for each such identified practitioner in the area.

The Rhode Island Department of Health has, we feel, used the best population estimates available to it, although others also exist. It has, however, in the main relied upon *but a single information source* for the data required under 2. and 3. above, namely the results of questionnaires (voluntary in nature) accompanying the required annual applications for re-registration of medical licensure. We feel that additional sources of information are readily available, are more accurate in many respects, and carry with them the authority of informed peer knowledge and evaluation. We will refer in detail to these other informational sources, after citing two area examples of what we believe to be faulty calculation of the basic Population: FTE ratios.

The first example, which we cite only in outline, is that of the Burrillville-Foster-Glocester Area. After a very considerable struggle by one physician with assistance from RIMS the underserved designation was very recently withdrawn on the basis of a recalculation of FTE.

The second example we shall present in some detail, since the designation is still under active re-evaluation. Our purpose is to criticize the methodology rather than the designation *per se*, as it applies to the *applicant* agency. The area is the city of Central Falls. The original evaluation of the Rhode Island Department of Health in a communication to RIMS dated July 24, 1980 would indisputably qualify the area for its awarded designation. The proposed designation was disputed in detail by Pawtucket Medical Association, Inc. (PMA) in correspondence to the Rhode Island Department of Health dated August 28, 1978 on the basis of allegedly inaccurate FTE counts. It was later also contested unsuccessfully by RIMS in November 1978 correspondence with a regional DHEW office in Boston.

RIMS and PMA have obtained information by personal inquiry of several physicians, by checking hospital privileges, by consulting peer opinion, by conversation with Blackstone Valley Citizens Action Program, Neighborhood Health Center (BVCAP NHC), and by analysis of an eight week period at Blackstone Valley Physicians Group, Inc. (BVPH). The results in out opinion clearly disqualify Central Falls as a medically underserved area on the basis of population to FTE ratio (although quite possibly *not*, were o*ther criteria* used for such designation).

It is not difficult to identify the reasons for the differences in the two assessments, each in our opinion honestly, sincerely, and objectively accomplished. The major problem originates in the reliance of the Rhode Island Department of Health on the questionnaire responses. The purposes of the questionnaire are inadequately understood and therefore mistrusted by a very substantial number of physicians. This leads to misreporting or non-reporting of hours/week as a single example. Secondly, the unverified self-declaration of specialty may have little relationship to the type and amount of services actually delivered.

RIMS does not wish to discount utterly the value of the questionnaire approach, but we very strongly feel that the questionnaire analysis, region by region, should be cross-checked for accuracy with the files or rosters of all physicians (members or not) in the area of each district or county society area (MD or DO), which are maintained by those societies as a condition of their charters from the RIMS. A further indicator of professional activity as it involves hospitalized federal patients could probably be obtained from Rhode Island Professional Standards Review Organization (RIPSRO). Other information sources are obviously available from private and other sources.

It is the opinion of RIMS leadership that if a *minimum* of two of seven medically underserved designations have inaccurately been made, such a 28.6 percent error rate is indefensible. We feel it is attributable to methodology and not to intent, since it is abundantly clear that the Rhode Island Department of Health staff feel that Rhode Island is in a physician surplus status. We, therefore, have offered the above sources of verification of data, which we feel should be rapidly accessible to the Rhode Island Department of Health when needed from our county and district societies and from the Rhode Island Association of Osteopathic Physicians and Surgeons at the present time, and we hope centrally from RIMS computerized data within 6 to 18 months.

New Locations

Harvey M. Baumann, MD
115 Governor Street
Providence, RI 02906
(Plastic, Reconstructive, Hand and Cosmetic Surgery)

George N. Cooper, Jr., MD
(additional office)
840 Greenwich Avenue
Warwick, RI 02886
(Thoracic and Cardiovascular Surgery)

Larry Schoenfeld, MD
One Randall Square, Suite 306
Providence, RI 02904
(Internal Medicine)

Medical Record Confidentiality

There has been an increasing trend in recent years in the US toward permitting patients access to their medical records, as indicated by several presently existing pieces of state and federal legislation.

The subject was introduced in the form of a resolution at the December, 1978 Interim Meeting of the AMA House of Delegates. The AMA Board of Trustees and the Council on Medical Service were asked in the resolution to study and report on the effects of state statutes which provide for patient access to information contained in their medical records. The resolution called for particular attention to the effects on the patient-physician relationship, patient care, patient compliance with therapeutic programs, and the incidence of professional liability litigation.

Following the 1978 resolution, which was approved, the Council polled state medical associations and national specialty societies, and found:

(1) 18 of the 45 state medical associations responding reported that legislation dealing with patient access to records was then in effect in their jurisdiction, and the majority of these laws — 14 — had been in effect since 1976. A majority of respondents in this category indicated that the legislation had no negative effect on the physician-patient relationship, quality of patient care, patient compliance with therapeutic programs, or liability litigation.

(2) 27 of the responding state medical associations did not have such legislation in effect, and opinions as to the probable effects of such legislation showed a majority of the respondents predicting harmful effects on the patient-physician relationship and an increase in professional liability litigation.

(3) Of the 35 responses from 56 medical specialty societies polled, a majority predicted a harmful effect on the physician-patient relationship, no effect on

(Continued next page)

Medical Meetings

OCT. 1980							
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October

1 Bioethics Committee Meeting; Diocesan; Chancery Building, Providence; 800 am
1 Rhode Island Chapter; American Academy of Pediatrics; regular meeting; Newport; evening
2 Blue Cross Board; regular meeting; 5:30 pm
6 Rhode Island Medical Society Council; regular meeting; 6:00 pm
8 RIMS Administration Meeting with RI Department of Health; 9:30 am
8 Miriam Hospital Staff Association; outing and dinner dance; Kirkbrae Country Club
8 New England Pediatric Society; fall meeting
8 Washington County Medical Society; regular meeting; Mental Health Building; Westerly; afternoon
9 RI Dermatological Society; regular meeting; Rhode Island Hospital; morning
11 New England State Medical Societies; regular meeting; Sheraton Sturbridge Inn, Sturbridge, Massachusetts (rooms, suites available; call 413 736-7301 to make it a weekend)
14 Providence Surgical Society; regular meeting; Squantum Club
15 RI Thoracic Society; Faculty Club, One Megee Street, Providence; 6:30 pm
16 RI Radiology Society; Marriott Inn, Providence
16-17 RI State Nurses Association Annual Meeting; Marriott Inn, Providence
17-18 Third National Invitation Conference for Physician Negotiators; Hilton Hotel, Las Vegas, Nevada
18-19 New England Society of Allergy; fall meeting; Sheraton-Islander Inn, Newport
20 Blue Shield Board; regular meeting; 6:00 pm
21 RI Otolaryngological Society; dinner meeting; RIMS Building; 6:30 pm
21 Newport County Medical Society; regular meeting; Castle Hill, Newport
23 RI Dermatological Society; regular meeting; VA Medical Center; morning

November

11 RI Society of Allergy; fall meeting; University Club; 6:30 pm
12 Providence Medical Association; regular meeting; Roger Williams General Hospital Dining Room
13 RI Dermatological Society; regular meeting; Rhode Island Hospital
25 RIPSRO Annual Meeting; RIMS Auditorium; evening

December

1 Rhode Island Medical Society Council; regular meeting; 6:00 pm
2 SPARI Annual Meeting; dinner meeting; Cranston General Hospital (David Hallmann, MD will host AMA speaker on hospital relations)
2 Providence Surgical Society; regular meeting; Squantum Club
3 RIMS Interim Meeting (David Hallmann, MD, Chairman will host AMA speaker on hospital relations)
5 Organization of State Medical Association Presidents (OSMAP); regular meeting; San Francisco
7-10 AMA House of Delegates, Interim Meeting; San Francisco
10 New England Pediatric Society; regular meeting
15 Blue Shield Board; regular meeting; 6:00 pm
16 RIMS Christmas Party; 6:00 pm; (presentation of district society charters and past presidents gallery showing)

Medical Record Confidentiality *(continued)*

patient compliance with therapeutic programs or on the quality of patient care, and an increase in the incidence of litigation.

The Council's conclusions based on this poll and subsequent studies stress that favorable responses were received from states who had actually experienced legislation providing for direct patient access to records; and that allowing patients access to information in their records has, on the whole, a favorable impact on patient care and physician-patient relationships, provided that appropriate safeguards are incorporated in the legislation.

At the 1980 meeting of the House of Delegates the Council on Medical Service urged that the development of legislation concerning patient access to medical records should continue to be the prerogative of the individual states, and that the AMA should prepare model legislation or model amendments to help states desiring to act legislatively on this issue.

Examples of the types of provisions which might be desirable in model legislation, according to the Council, include:

(1) Limiting the patient's right to his records when the information contained therein is considered harmful to his health by a physician (legislation in Minnesota and some other states contain this waiver).

(2) Allowing access by the patient's authorized representative when the condition under (1) prevails.

(3) Guaranteeing that the legislation applies to all types of medical records, held by all types of providers or health care institutions.

(4) Allowing flexibility of the form in which records are provided to the patient.

(5) Providing a mechanism for appeal by an individual denied access to his records under the terms of the legislation. ■

Aches and Pains . . .

• A series of recommendations designed to improve productivity in the delivery of health care services has been adopted by the National Council on Health Planning and Development. The recommendations propose: undertaking "major educational initiatives" to improve physician knowledge about the best ways to improve health; improving the regional allocation of health care resources; helping consumers to become more informed about the way the health care system functions and what they can expect from it; increasing the participation of labor, industry and consumers in order to help ensure that the "needs of the vulnerable are not neglected"; stimulating the training of a greater proportion of health care personnel concerned with primary and preventive care in proportion to other health care practitioners; increasing incentives to encourage longer range health and productivity gains through basic and clinical research; strengthening the national health service corps as a means of improving the availability and productivity of health care in presently underserved areas; paying hospitals for their services on a prospective rather than a retrospective cost related basis as a way of developing incentives to efficiently utilize resources; changing the present usual, customary and reasonable method of reimbursing physicians in ways to encourage them to consider appropriateness and effectiveness in the use of health care.

• The American Medical Association's committee on PSRO guidelines is disseminating complimentary copies of a booklet entitled *Some Practical and Legal Guidelines for Members of Boards of Directors of Professional Standards Review Organizations.* The booklet is designed to inform physicians as to their general and fiduciary responsibilities as PSRO board members. AMA spokesman Dewitt Miner said that the booklet is seen as a necessary supplement to information provided by the American Association of PSROs (AAPSRO) and by HHS in order to avert federal defunding due to lack of board accountability. A copy of the booklet has been sent to each state, local, and national medical specialty society as well as all PSROs. Additional copies are available from the Department of Health Care Delivery Systems, AMA Headquarters, 535 North Dearborn, Chicago IL 60610.

• A new reference book for physicians, dieticians, health professionals, and students titled *Sodium and Potassium in Foods and Drugs* is available for $5.00 from Op-80, AMA Order Department, PO Box 821, Monroe, WI 53566.

• It appears that the government bureaucracy and those it supports is at an all-time high. On paper, the Department of Health, Education and Welfare (Now HHS) in 1978 had a reported payroll of 145,000 employees. However, this number included only actual federal employees. In fact, more than six times that number earned their keep through HEW support under grants and contracts as follows: in local governments, 572,700; in state governments, 84,000; at universities, 87,700; at research institutions, 33,000; consultants, 113,900; others, 88,900. The total is 980,200.

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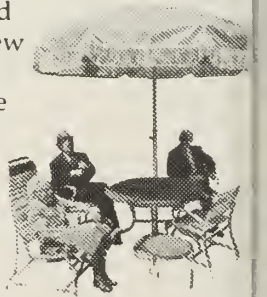

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PRESIDENT'S CORNER

RIMS and AMA Membership: Why Me? Why Not Me?

Peter L. Mathieu, Jr., MD

Ah, the sweet smell of success. There you are, working hard and being number one in the world's most competitive and honored profession — medicine. Here we are, your administration, elected by you the membership, presenting the fifth in our monthly series of observations on the Rhode Island Medical Society.

Satisfied? We aren't. You shouldn't be satisfied either. Even if you're in the lead, and it's always anybody's race in this profession, let's face it — with the competition on your heels and the changing economy playing havoc with your plans; with government, consumers, just about everybody, wanting a piece of the action — you could become at any time an also ran. Is medicine to remain a profession, or will these extraneous forces reduce it to the level of a trade?

What separates the winners from the losers in life? Who has the ability to get the inside track in the marketplace? Who has the ability to know when to move and to set the pace? This administration believes the Rhode Island Medical Society should be the key organization, which, by careful analysis, will be able to accurately forecast conditions. It should be able to predict, and also to influence, what lies ahead. Take it straight from the horse's mouth. Races are not won by speed; they are won by strategy.

Do the 2,000 licensed physicians in Rhode Island want the Rhode Island Medical Society to remain an organization with an annual budget of $250,000, structured along the lines by which it has existed since 1812? Do they want a different, expanded organization? Do they want no organization?

Do you believe that the goose which laid the golden egg will last forever? Do you believe that in the present day physicians are putting out all that they should?

Are you a member or non-member of a district county medical society, a member or non-member of the Rhode Island Medical Society, a member or non-member of the American Medical Association, a member or non-member of a specialty society?

Do you believe that you are immortal and able to shoulder all of the world's burdens? Or, at the opposite extreme, do you ignore the world's troubles and try to reap only its benefits? There are 400,000 physicians in this country. Fewer than 300,000 are members of the AMA, an organization with an annual budget of $64,000,000 and 900 employees. Do you think that this organization is not working for you. If so, then let the AMA know this in writing, and verbally. For heaven's sake, let this administration know your thoughts, because we are your elected officials, fellow physicians, responsible for maintaining the status of medicine as a profession, and for maintaining your status as a professional.

The problem in this country and in this profession is not too much public relations and communications, but too little. Far too many good causes flounder because they are poorly presented. Too many worthwhile medical society programs fail because professional help in articulating cases convincingly is lacking.

Communications are growing, because forces in society are demanding it. Government is under constant pressure to provide information; and the Rhode Island Medical Society and the AMA, also, must continually make efforts by communications to keep the support of members, employees, pa-

Fiske Fund Prize Dissertation 1980

The Trustees of the Fiske Fund of The Rhode Island Medical Society announce the following for the Prize Dissertation of 1980:

Medicine and Regulatory Law: Is Rationing Inevitable?

The awarding of prizes and the amounts are made at the discretion of the Trustees. Awards, if any, may vary from a minimum of $200 to a maximum of $1,000. The dissertation will be particularly graded on the basis of original work by the author. The competition is not restricted to physicians. Each competitor for the premium is expected to conform with the following regulations:

To forward to the secretary of the Trustees on or before the fifteenth day of December, 1980, free of all expense, *a copy of his dissertation with a motto thereon, and also accompanying it a sealed envelope bearing the same motto inscribed on the outside with his name and address within.* The author's name should appear on the title page of the manuscript.

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tients, and consumers. We must answer our critics effectively. Non-profit organizations such as the AMA and the Rhode Island Medical Society will perish if they do not do this.

As our society becomes more complex, the problem of generating better mutual understanding among those in government and in politics; in business and industry; in the work force; in the intellectual, educational, and religious communities; and in the non-profit sectors calls for increased professional communications. This administration does not believe that the Rhode Island Medical Society at this time is effectively communicating with its members, let alone with non-member licensed physicians in Rhode Island or with special interest groups.

This administration has asked selected physicians and non-physicians why they join an organization. Their answers are enlightening:

"On the whole all organizations are lacking, but I want to believe in them. I think they mean to be helpful."

"Organizations are in a state of turmoil; they should develop the know-how to solve problems; they should have a single purpose; they should improve communications."

"The Rhode Island Medical Society should be an organization to which I can contribute and from which I can learn."

"The Society should provide opportunities to meet people, to help to broaden experience; it should be fun."

"The Society should enter into agreements and negotiations; it should present all of the facts; it should safeguard the future for its members."

"I would like to see the Society preserve my voice in the governing of health care in this community."

"The Society has qualities of excellence, but it doesn't seem to help me; I know you want the very best people and to support the most credible projects, but I'm not too sure that the Rhode Island Medical Society or the AMA really represent me; I would like the Society to set the tone for me."

As your fellow physician, I share your thoughts and questions. I pay my dues to the Rhode Island Medical Society (now $175.00); the Providence Medical Association ($50.00); the American Medical Association ($250.00). As a hardheaded businessman I want something for my money, too. As a strategy to get something for your money, my recommendation is to use these organizations to find out all you can about the community and its interfaces, about the AMA and its workings, things not taught in medical school.

As President, I am working to give the Rhode Island Medical Society back to its members in much the same way the AMA was given back to its members in 1974, when Dr. James Sammons, a street doctor from Texas, was elected Executive Vice President.

Do you really believe you can go it alone indefinitely? There is no magical potion; it simply boils down to this: in order to survive the physicians in Rhode Island and in this country must belong to their organizations and give to the best of their ability, as well as receive.

Several tasks demand our immediate attention. The first of these is to confirm an absolute sense of family in our honorable profession. We must establish a philosophy of togetherness, and give forth a true image of unity within our profession. There is no room in our system for bickering between specialty societies, medicine and surgery, government physicians, medical school physicians, medical students, medical residents, and even women physicians. For example, it is worthwhile for the American College of Surgeons to develop criteria for identification and designation of specific settings best utilized for performance of specific procedures. It is worthwhile for each specialty society to do this. But who represents all physicians? *Only your State Medical Society and the AMA can mold together all specialized perspectives into an aggregate view.*

This administration asks you for a stronger commitment. It urges you to join or renew your interest in your local State Society and the AMA. This administration wants the unified support of all physicians.

Dr. Carl G. Evers, President of the Mississippi State Medical Association, poses a question: "Where will you be when the lights go out on the practice of medicine as we know it today?". The membership of any medical association can be broken down into four groups. One group, comprising about 10 per cent of the membership, devotes extensive time to the activities of the association.

This is the "gung-ho" group. Another group, comprising about 30 per cent of the members, is involved in the association's activities to a limited extent. They attend an occasional meeting. A third group, comprising about 50 per cent of the membership, are "checkbook members". These members unburden their professional consciences by paying dues, but their attitude is: "It's all your, boys. I'm going to play golf". A fourth group, 10 per cent of the membership, can be labelled "dissidents". To this group nothing is ever right. There is also a fifth group, which is comprised of over 700 Rhode Island physicians, who, for whatever reason, do not belong to the Society. (More than 1,000 Rhode Island physicians do not belong to the AMA.)

The bylaws of the Rhode Island Medical Society state that "certain rights and duties devolve on the President . . . to act as the real head of the profession in the State, and when he deems it advisable or necessary, to visit personally, or by representative of his own designation, the various component societies, and to assist the councilors in building up the component societies and in making their work more practical and useful". This administration has pledged itself to do this. This administration believes that *the lights aren't going to go out,* and asks you to support the Rhode Island Medical Society, the AMA, and other medical organizations — *to keep the lights on.*

You don't have to be a mathematics professor to make sense out of basic finance. If the medical profession as we know it is to survive, then every physician must pay his dues. Also the administration needs to know from you in what manner the Rhode Island Medical Society can service your needs more effectively now and in the future. This administration seeks your help to devise new ideas on how to keep communications open at all levels for our physicians. Do you think it's fair to live under the protective umbrella of the medical profession without paying your dues and giving us your suggestions? We in this administration want to give the Rhode Island Medical Society back to you to make policy; to plan strategy for survival; to lead this state and this country in protecting and improving health care delivery for our citizens.

You know the things that can hinder our efforts: petty rifts that widen; frequent misunderstandings between physicians; costly mistakes due to unclear directives; low morale. I believe all these are the result of breakdown of communications. This administration wants to turn this situation around.

Take a good look at what your State Medic Society is doing. For those just starting out as ph sicians, or those about to assume additional respo sibilities within the profession, there is no better w to learn the ropes than by joining your Society a the AMA, and by combining your personal sty with that of your elected leaders, to form aggregate power base, and a strategy to achie success. Let's not get cold feet every time we me the government or the public or anyone else, a retreat to our individual offices, hoping the gold goose will continue to lay the golden egg. This a ministration promises you effective leadership. asks you to promise your confidence, support, a ideas.

Time is money. We must learn to use time as resource. Your dues will enable this administrati more accurately to measure our staff's performan and to clarify its responsibilities in the time allotte

Let us start by building a working partnersh among ourselves. Let us encourage greater partic pation of Foreign Medical Graduates (FMGs) a student groups at all levels of organized medicin This administration with the assistance of De Stanley M. Aronson and Doctor Pierre Gallet Vice President for Medical Affairs, Brown Unive sity, is encouraging student and resident physici membership in the Rhode Island Medical Socie and the AMA, and providing them a voice in t governing bodies of our organizations. There is charge for student membership in the Rhode Isla Medical Society.

This administration recognizes we ha problems, but it also recognizes that we have o portunities. We must spend more time informin all of you how the Rhode Island Medical Society governed. We hope to open up opportunities for a pointments and election to office for all physicia in the seven district societies. We hope to strengthe our own programs, and to provide sound asses ments of the programs of other health institutio and organizations in the community. To do this w need your dues.

I ask you to continue your membership or, if yo are not a member, to join the Rhode Island Medic Society and the AMA, so that we may have the fi ancial wherewithal to continue our work, so that w may stand tall in the attainments of physicians an the Rhode Island Medical Society in the 1980s.

Peter L. Mathieu, Jr., MD
President

EDITORIALS

Whither Duodenal Ulcer?

Two recent reports have brought into sharper focus the present status of the treatment of duodenal ulcer and provide some hints as to the future. The first, a group of papers from the Mayo Clinic, is titled "Symposium on Duodenal Peptic Ulceration — 1980". The second, "The Declining Role of the Surgeon in the Treatment of Acid-Peptic Disease", is an editorial by Israel Penn in the *Archives of Surgery*.

In the first set of papers an attempt is made to judge without bias the results of three surgical procedures as performed at the Mayo Clinic and the likely impact of the introduction of H_2-blocking agents. The three surgical procedures reviewed are truncal vagotomy and pyloroplasty, proximal gastric vagotomy, and vagotomy and antrectomy.

In the Mayo Clinic experience the recurrence rate for vagotomy and pyloroplasty in elective cases was 13.6 per cent, and in emergency cases 4.5 per cent. The overall operative mortality was 4.4 per cent. Ninety-five per cent of the recurrences occurred in the elective cases. The conclusion reached was that elective vagotomy and pyloroplasty for the cure of chronic duodenal ulcer disease "does not sufficiently protect against recurrence and that its popularity remains mainly due to the technical ease of the procedure".

In the Mayo series of proximal-gastric vagotomy adverse sequelae such as delayed emptying, diarrhea, and reflux gastritis occurred in less than three per cent of patients, while recurrent ulceration occurred in 4.9 per cent. There was no mortality. The follow-up ranged from 6 to 78 months, with a mean of 39 months. A three-year follow-up is certainly inadequate in duodenal ulcer. The authors concluded "that proximal gastric vagotomy is an effective, safe, and satisfactory operation for chronic ulcer *over the short term*" (italics added).

In a retrospective analysis by the Mayo Group of 466 patients subjected to vagotomy with antrectomy or hemigastrectomy the mortality was a respectable 1.1 per cent. Severe sequelae such as diarrhea and dumping occurred in less than one per cent of cases. The average follow-up period was 17 years, and the ulcer recurrence rate was an excellent 0.7 per cent or 1.4 per cent if two cases of gastrojejunitis are included. Based on the reasonable criteria of long-term cure and low morbidity and mortality it is concluded that this combination of procedures is the operation of choice for most patients with chronic duodenal ulcer disease. A gastroenterologist in the group, however, favors parietal cell vagotomy on the basis that it is associated with less morbidity, even though "it may be somewhat less effective" than gastric resection with vagotomy in terms of preventing ulcer recurrence.

The advent of newer drugs in the treatment of ulcer disease probably has altered the outlook significantly. The Mayo Group point out that medical treatment, unlike surgery, does not provide a permanent cure. However, newer more powerful H_2-receptor antagonists, as well as other promising unrelated drugs yet to be identified, are being developed. Keeping patients on medical treatment now may involve some risk and inconvenience, but may permit them to benefit from later developments as yet not available that may reduce the need for surgery.

The paper of Penn notes a recent sharp decline in Veterans Administration hospitals and elsewhere in the number of referrals for peptic ulcer surgery. This is attributed to the introduction of cimetidine, which he describes as the most powerful gastric antisecretory drug known. In addition to its significant impact on the treatment of peptic ulcer it has revolutionized the management of the Zollinger-Ellison syndrome. There is also evidence that cimetidine may prevent and possibly control bleeding from severe hemorrhagiogastritis (stress ulcers). Penn too notes that a number of other new drugs are being investigated.

Cimetidine is being evaluated in many centers on its own merits in the management of severe upper gastrointestinal bleeding due to peptic ulcer, and also in conjunction with embolization with blood clot or Gelfoam,® or with endoscopic electrocoagu-

lation or laser photocoagulation. It has been suggested as well for bleeding in Mallory-Weiss tears together with vasopressin administration.

When maintenance therapy with cimetidine is discontinued, there is a high rate of recurrence, which suggests that treatment may have to be continued indefinitely. Most physicians are as yet reluctant to recommend this course, as the side-effects of long-term cimetidine or the risks of permanent H_2-blockade are unknown. Many patients, however, when advised to have surgical intervention, refuse on the ground that they prefer to continue with cimetidine. Penn concludes:

"We are living in a new therapeutic era as regards the acid-peptic diseases. Whether or not one or another of these new remedies will have a significant long-term impact on the management of these disorders remains to be seen. The entire history of the acid-peptic diseases is filled with nostrums that had a brief moment of popularity and were then discarded. Controversies with regard to their management will be settled only with controlled trials that permit a clear assessment of the new treatments as compared with surgery in terms of efficacy, safety, acceptability, and cost."

References

[1]van Heerden JA: Symposium on duodenal peptic ulceration — 1980. Introduction. Mayo Clin Proc 55:3, Jan 80.

[2]Kelly KA: Which operation for duodenal ulcer. Mayo Clin Proc 55:5, Jan 80.

[3]van Heerden JA, Kelly KA, Dozois RR, et al: Proximal gastric vagotomy. Initial experience. Mayo Clin Proc 55:10, Jan 80.

[4]Pemberton JH, van Heerden JA: Vagotomy and pyloroplasty in the treatment of duodenal ulceration. Long-term results. Mayo Clin Proc 55:14, Jan 80.

[5]Hubert JP Jr, Kiernan PD, Beahrs OH, et al: Truncal vagotomy and resection in the treatment of duodenal ulcer. Mayo Clin Proc 55:19, Jan 80.

[6]Malagelada JR: Medical versus surgical therapy for duodenal ulcer. Making the right choices. Mayo Clin Proc 55:25, Jan 80.

[7]Penn, I: The declining role of the surgeon in the treatment of acid-peptic diseases. Arch Surg 115:134, Feb 80.

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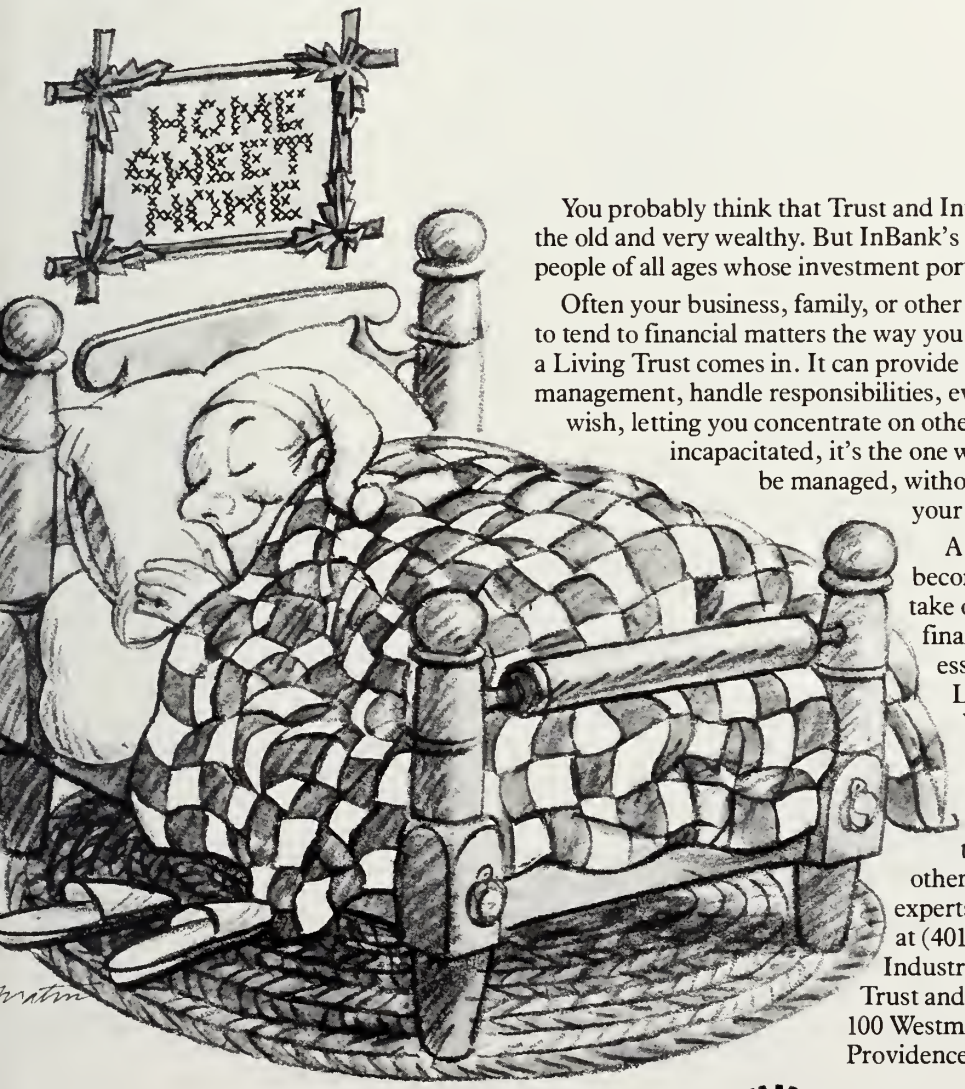

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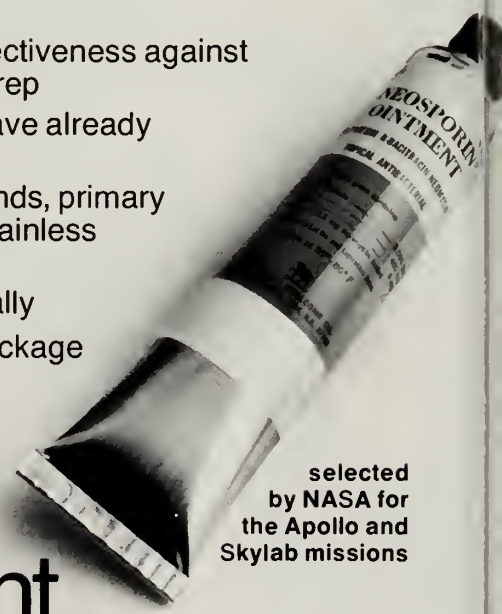

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SPECIAL EDITORIAL

Is the Rhode Island Medical Society Anachronistic?

This rhetorical question can be answered only in the affirmative. Since the Rhode Island Medical Society was founded (1812), there have been extensive, far-reaching changes 1) in the character of its membership, 2) in the socio-economic milieu, and 3) in public opinion and the attitude toward physicians. My answer above is predicated upon these changes.

Change in Character of Its Membership

When the Rhode Island Medical Society was founded, most of its members were general practitioners with the exception of a few specialists in the larger cities. This character of the membership remained essentially unchanged until the end of the Second World War, when specialization began to be heavily underwritten by the government. Then, gradually subspecialization supervened, with an increasingly marked decrease in the numbers of general practitioners.

New specialty and subspecialty groups developed their own medical organizations and specialty journals, which resulted locally in a loss of interest in and affiliation with the Rhode Island Medical Society. National organizations of the various specialty groups became the focus of interest for physicians; leaving state medical societies as organizations of physicians whose common bond is that they are all MDs, but who are myopic to forces which are trying slowly to destroy the finest system of medical care ever developed.

Change in the Socio-Economic Milieu

Socio-economic developments have profoundly affected the environment in which medicine is practiced. The past three decades have been marked by an explosive growth in third party payers, and by involvement also of the federal and state governments in reimbursement, which has had a dramatic effect on the relationship of physicians with their patients and with each other.

The third party payers are now attempting to regulate fees by various methods, such as by assignment of fees in the case of the federal government, by law in the case of the Rhode Island Medicaid programs, and by various other methods.

The federal government is now engaged in health planning through Public Laws 93-641 and 93-69. The ostensible purposes of these laws are to guarantee access to care, to assure quality of care, and to contain costs. In effect, however, the laws *could mark the beginning of the rationing of medical care in our country,* a most dangerous phenomenon.

Since the end of the Second World War there have been also great changes in the delivery of medical care. In 1945 there were for each physician three ancillary or supporting personnel; now there are 18, reflecting the great strides made in biomedical technology. We now have physicians assistants and nurse practitioners, who are allowed to carry out many tasks formerly performed only by physicians. Professional ethical codes are changing, also. Through legal channels the Federal Trade Commission and paramedical groups have brought about rulings that advertising is ethical. Podiatrists are now allowed to operate in hospitals. The list is endless . . . .

Changing Public Attitude and Public Opinion

The image of the doctor is being destroyed. Malpractice suits are occurring in alarming numbers, most of which are unjustifiable and only result in an increase in the cost of medical care. The public in fact has been encouraged to seek second opinions for elective surgery. Alarming charges were made that this procedure was saving hoards of people from needless surgery. A recent controlled study in the *New England Journal of Medicine,* however, appears to have disproved these allegations.

A Suggested Model for a Reorganized Society

The following is offered as a jumping off point to initiate and solicit ideas from our membership.

The *House of Delegates* should be composed of the presidents of all the specialty societies as recog-

nized by the AMA. The presidents of all county medical societies should also be members. A specialty organization with more than fifty members should be allowed one representative for each fifty members (up to five representatives).

The chiefs of all established hospital staffs should be members. The Brown University Medical School should be represented by two members chosen from the MD faculty and two members from the PhD faculty. Other representatives should be the Director of the Rhode Island Department of Health, presidents or equivalent officers of the podiatry society, physicians assistant society, nurse practitioner society, Blue Cross/Blue Shield, nurses association, pharmacy association, and the AFL-CIO. Probably others should be included also. All representatives should have a vote.

The *Council* of the Medical Society should have as members the presidents of all AMA recognized local specialty societies.

With this new model the Society would be able to initiate policy in keeping with the times. It would be obvious to all that the prime reason for existence of the Medical Society is the welfare of our patients. No longer could there be suspicion of our motives, as so many groups would be privy to our deliberations and would realize fully our sincerity. These changes may seem radical and drastic, but critical conditions call for drastic changes.

We would be well advised to study thoroughly the advice once offered by John Gardner, who said:

"I am always puzzled by people who talk as though the advocates of change were just inventing ways to disturb the peace in what would otherwise be a tranquil community. We are not seeking change for the sheer fun of it. *We must change to meet the altered circumstances. Change will occur whether we like it or not.* It will either be change in a good and healthy direction or change in a bad and regrettable direction. There is no tranquility for us."

What Other Changes Should Be Effected To Rectify the Situation

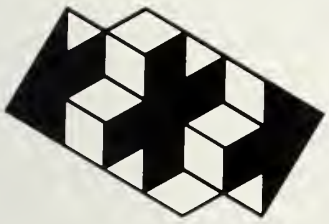
The objectives of the Rhode Island Medical Society originally were: 1) to elevate and maintain the standards of medical care, 2) to expose quackery, and 3) to serve as a clearinghouse for the dissemination of scientific knowledge by meetings, letters, and the *Rhode Island Medical Journal.*

What changes in these objectives must be made to meet our present goals? The first two objectives are important and must be pursued. However, the function of disseminating scientific knowledge has now been assumed to a considerable extent by various specialty societies and their journals. Our meetings and our *Journal* should be devoted increasingly to issues involving delivery of medical care, alternative systems, and ways to avoid at all costs the rationing of medical care.

We shall do well to continually heed the warnings of Doctor Leo Alexander, the consulting psychiatrist to the Secretary of War, on duty with the office of the Chief Council for War Crimes at the Nuremberg Trials, who in the *New England Journal of Medicine* of July 14, 1949 documented historically the frightful consequences in Nazi Germany of the rationing of medicine. American physicians are still far from the point at which they think that the likelihood of rehabilitation should determine the amount of time, effort, and cost to be devoted to a particular type of patient. Yet a movement for euthanasia *is* present in our midst.

In Dr. Alexander's words: "The ease with which destruction of life, instead of educational or ameliorative measures, is advocated for those considered either socially useless or socially disturbed, may be the first sign of loss of creative liberty in thinking, which is the hallmark of democratic society. All destructiveness ultimately leads to self-destruction . . . The destructive principle once unleashed, is bound to engulf the whole personality and to occupy all its relationships. *The ameliorative point-of-view maintained in relation to all others is the only means of self-preservation."*

Charles E. Millard, MD
President-Elect
Rhode Island Medical Society



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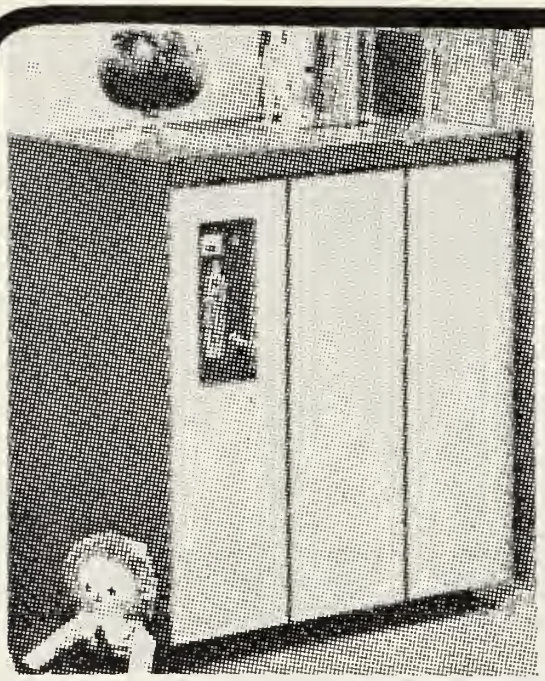

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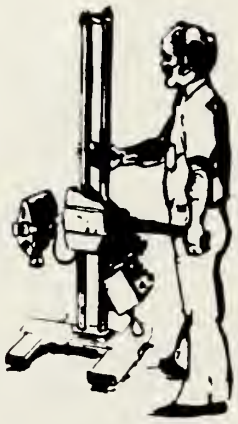

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WARNINGS: If tolerance develops, the recommended dose should not be exceeded in an attempt to increase the effect, rather, the drug should be discontinued. Tenuate may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle; the patient should therefore be cautioned accordingly. *Drug Dependence*: Tenuate has some chemical and pharmacologic similarities to the amphetamines and other related stimulant drugs that have been extensively abused. There have been reports of subjects becoming psychologically dependent on diethylpropion. The possibility of abuse should be kept in mind when evaluating the desirability of including a drug as part of a weight reduction program. Abuse of amphetamines and related drugs may be associated with varying degrees of psychologic dependence and social dysfunction which, in the case of certain drugs, may be severe. There are reports of patients who have increased the dosage to many times that recommended. Abrupt cessation following prolonged high dosage administration results in extreme fatigue and mental depression; changes are also noted on the sleep EEG. Manifestations of chronic intoxication with anorectic drugs include severe dermatoses, marked insomnia, irritability, hyperactivity, and personality changes. The most severe manifestation of chronic intoxications is psychosis, often clinically indistinguishable from schizophrenia. *Use in Pregnancy*: Although rat and human reproductive studies have not indicated adverse effects, the use of Tenuate by women who are pregnant or may become pregnant requires that the potential benefits be weighed against the potential risks. *Use in Children*: Tenuate is not recommended for use in children under 12 years of age.

PRECAUTIONS: Caution is to be exercised in prescribing Tenuate for patients with hypertension or with symptomatic cardiovascular disease, including arrhythmias. Tenuate should not be administered to patients with severe hypertension. Insulin requirements in diabetes mellitus may be altered in association with the use of Tenuate and the concomitant dietary regimen. Tenuate may decrease the hypotensive effect of guanethidine. The least amount feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdosage. Reports suggest that Tenuate may increase convulsions in some epileptics. Therefore, epileptics receiving Tenuate should be carefully monitored. Titration of dose or discontinuance of Tenuate may be necessary.

ADVERSE REACTIONS: *Cardiovascular*: Palpitation, tachycardia, elevation of blood pressure, precordial pain, arrhythmia. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride. *Central Nervous System*: Overstimulation, nervousness, restlessness, dizziness, jitteriness, insomnia, anxiety, euphoria, depression, dysphoria, tremor, dyskinesia, mydriasis, drowsiness, malaise, headache, rarely psychotic episodes at recommended doses. In a few epileptics an increase in convulsive episodes has been reported. *Gastrointestinal*: Dryness of the mouth, unpleasant taste, nausea, vomiting, abdominal discomfort, diarrhea, constipation, other gastrointestinal disturbances. *Allergic*: Urticaria, rash, ecchymosis, erythema. *Endocrine*: Impotence, changes in libido, gynecomastia, menstrual upset. *Hematopoietic System*: Bone marrow depression, agranulocytosis, leukopenia. *Miscellaneous*: A variety of miscellaneous adverse reactions has been reported by physicians. These include complaints such as dyspnea, hair loss, muscle pain, dysuria, increased sweating, and polyuria.

DOSAGE AND ADMINISTRATION: Tenuate (diethylpropion hydrochloride) One 25 mg. tablet three times daily, one hour before meals, and in midevening if desired to overcome night hunger. Tenuate Dospan (diethylpropion hydrochloride) controlled-release: One 75 mg. tablet daily, swallowed whole, in midmorning. Tenuate is not recommended for use in children under 12 years of age.

OVERDOSAGE: Manifestations of acute overdosage include restlessness, tremor, hyperreflexia, rapid respiration, confusion, assaultiveness, hallucinations, panic states. Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Overdose of pharmacologically similar compounds has resulted in fatal poisoning, usually terminating in convulsions and coma. Management of acute Tenuate intoxication is largely symptomatic and includes lavage and sedation with a barbiturate. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendation in this regard. Intravenous phentolamine (Regitine®) has been suggested on pharmacologic grounds for possible acute, severe hypertension, if this complicates Tenuate overdosage.

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References: 1. Citations available on request from Medical Research Department, MERRELL-NATIONAL LABORATORIES, Cincinnati, Ohio 45215. 2. Hoekenga, M.T., O'Dillon [Dillon], R.H., and Leyland, H.M.: A comprehensive review of diethylpropion hydrochloride. In, Central Mechanisms of Anorectic Drugs, S. Garattini and R. Samanin, Ed., New York, Raven Press, 1978, pp. 391-404.

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Please see last page for brief summary, including warnings, precautions, and adverse reactions.

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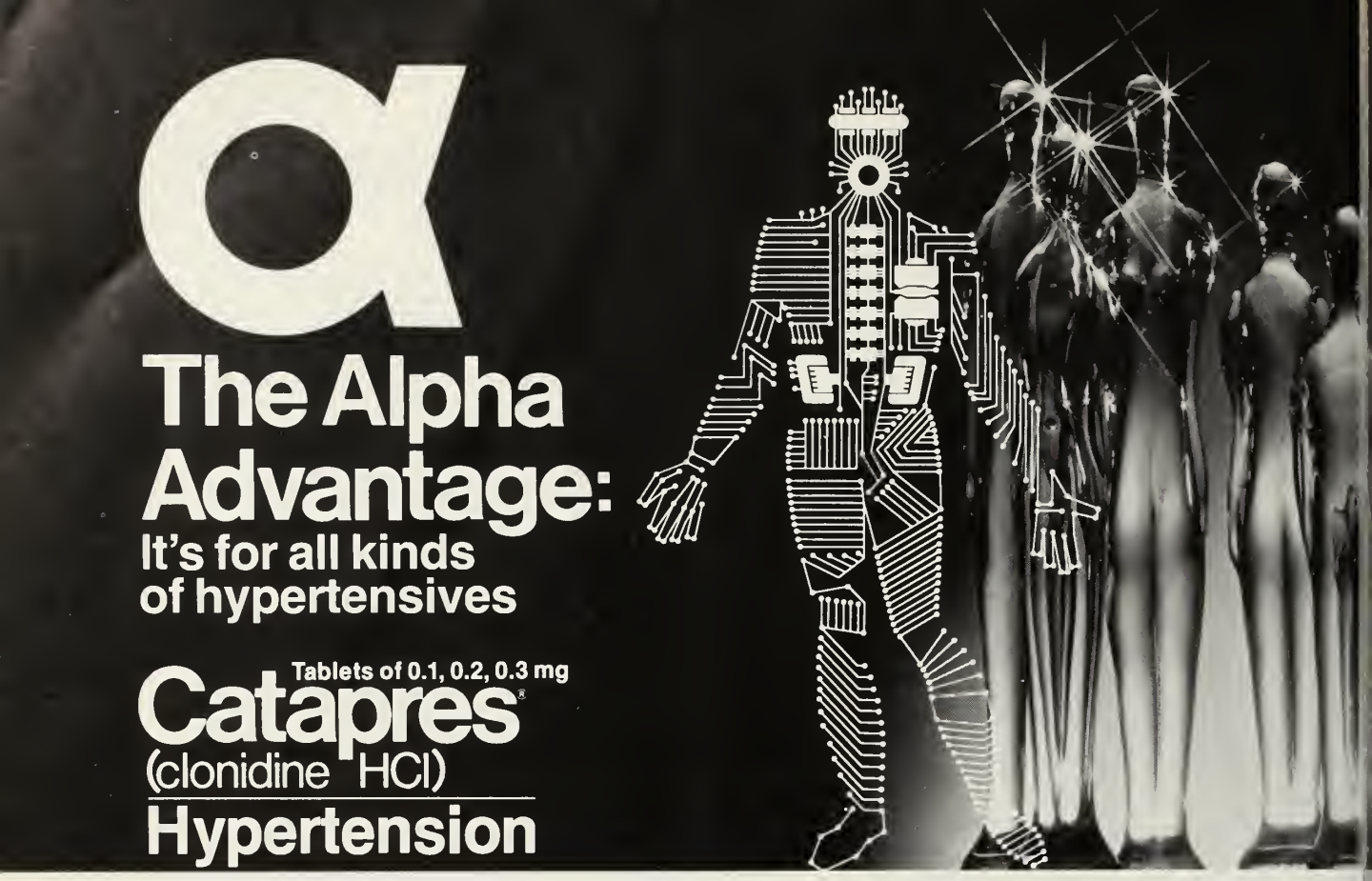

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Usage in Children: No clinical experience is available with the use of Catapres (clonidine hydrochloride) in children.

Precautions: When discontinuing Catapres (clonidine hydrochloride), reduce the dose gradually over 2 to 4 days to avoid a possible rapid rise in blood pressure and associated subjective symptoms such as nervousness, agitation, and headache. Patients should be instructed not to discontinue therapy without consulting their physician. Rare instances of hypertensive encephalopathy and death have been recorded after cessation of clonidine hydrochloride therapy. A causal relationship has not been established in these cases. It has been demonstrated that an excessive rise in blood pressure, should it occur, can be reversed by resumption of clonidine hydrochloride therapy or by intravenous phentolamine. Patients who engage in potentially hazardous activities, such as operating machinery or driving, should be advised of the sedative effect. This drug may enhance the CNS-depressive effects of alcohol, barbiturates and other sedatives. Like any other agent lowering blood pressure, clonidine hydrochloride should be used with caution in patients with severe coronary insufficiency, recent myocardial infarction, cerebrovascular disease or chronic renal failure.

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longer.

Adverse Reactions: The most common reactions are dry mouth, dro
sedation. Constipation, dizziness, headache, and fatigue have be
Generally these effects tend to diminish with continued therapy. T
reactions have been associated with the drug, some of them rare
instances an exact causal relationship has not been established.) Th
Anorexia, malaise, nausea, vomiting, parotid pain, mild transient abr
liver function tests; one report of possible drug-induced hepatitis wi
and hyperbilirubinemia in a patient receiving clonidine hydrochl
thalidone and papaverine hydrochloride. Weight gain, transient eleva
glucose, or serum creatine phosphokinase: congestive heart failure
phenomenon; vivid dreams or nightmares, insomnia, other behavio
nervousness, restlessness, anxiety and mental depression. Als
gioneurotic edema, hives, urticaria, thinning of the hair, pruritus nc
with a rash, impotence, urinary retention, increased sensitivity to alco
itching or burning of the eyes, dryness of the nasal mucosa, pallor, gy
weakly positive Coombs' test, asymptomatic electrocardiographic a
manifested as Wenckebach period or ventricular trigeminy.

Overdosage: Profound hypotension, weakness, somnolence, dimir
sent reflexes and vomiting followed the accidental ingestion of Catapr
hydrochloride) by several children from 19 months to 5 years of
lavage and administration of an analeptic and vasopressor led to
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Anaphylactic Reactions in Asthmatic Patients

Likelihood of Significant Reactions Is Dependent Upon the Specific Immunological Mechanism Involved

Guy A. Settipane, MD

A basic question in the field of immunology/allergy is whether atopy (asthma/allergic rhinitis) predisposes to acute anaphylactic reactions. A second question is whether asthmatics have a more severe reaction than other individuals when anaphylaxis does occur. These are important questions. If a high risk group can be identified, one should administer drugs to this high risk group with great caution and care. I shall attempt to answer these questions by reviewing immunoglobulin E (IgE) mediated reactions and non-IgE mediated reactions.

IgE mediated reactions are shown in Figure 1. An allergen reacts with its specific antibody of the IgE class attached to a mast cell and the mast cell in turn releases histamine, slow reactive-substance of anaphylaxis (SRS-A), and eosinophil chemotactic factor of anaphylaxis (ECF-A), as well as other mediators and, as a secondary response, prostaglandins. The amount of specific IgE on the mast cell depends on the production from specific IgE producing B lymphocytes and plasma cells. In turn, the amount of IgE produced by these B lymphocytes are regulated by T suppressor lymphocytes and T-helper lymphocytes. The amount of allergic mediators produced is modulated by cyclic AMP and cyclic GMP. These intracellular compounds in turn are regulated by adrenergic receptors (alpha and beta receptors) and the cholinergic receptors. For example, epinephrine will stimulate the beta receptor of a mast cell, which will then have an increased production of cyclic AMP. This in turn will inhibit the release of the allergic mediators such as histamine, SRS-A, and ECF-A. As an end result, the bronchospasm subsides. Stimulation of the cholinergic receptor with mecholyl causes a decrease in cyclic GMP, with a resulting increase release of allergic mediators. As an end result, acute bronchospasm may occur.

The IgE mediated reactions in asthmatics that we studied were insect or Hymenoptera allergy.[1-3] It is well documented that insect allergy is similar to penicillin allergy in that it is IgE mediated. IgE antibodies specific for insect venoms or penicillin products are known to be present in patients with clinical insect allergy or clinical penicillin allergy.

For our investigation of insect allergy, we considered only those cases with a definite systemic reaction to stings. The symptoms of such reactions included generalized urticarial/angioedema (Grade II), dyspnea (Grade III), or symcope (Grade IV). Patients with local reactions to a sting (Grade I) were not considered in our study (Table 1).

In 1972, we reported on an epidemiology study involving about 3,000 Boy Scouts! We first divided this population into those with atopy (asthma/hay fever) and those without atopy. We then determined the frequency of insect allergy in these two groups and found them to be about the same, (0.8 per cent) (Table 2). We concluded from this study that atopy does not appear to predispose to acute

Presented at the fall meeting of the New England States Chapter, American College of Chest Physicians, Providence, Rhode Island, December 12, 1979.

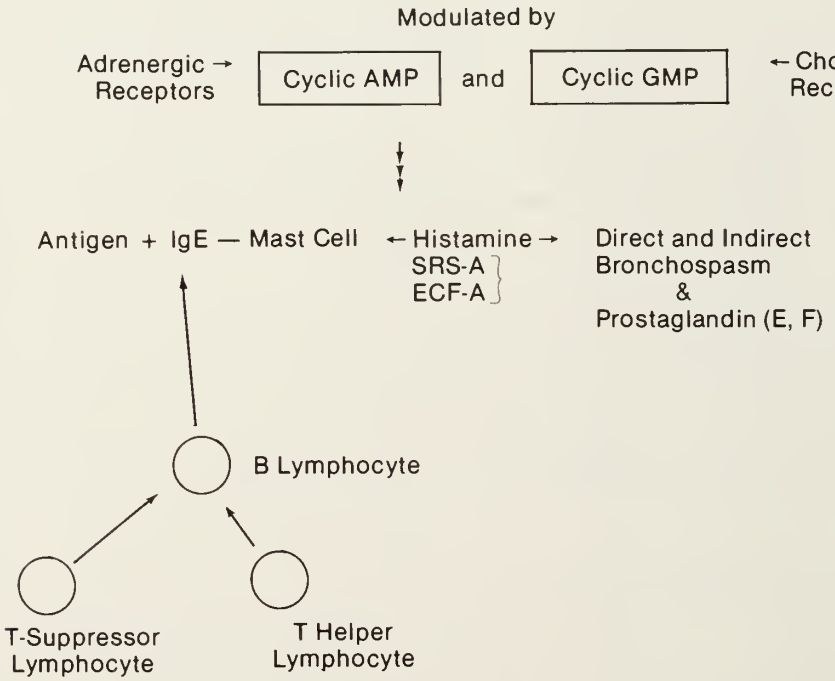
Guy A. Settipane, MD, Clinical Associate Professor of Medicine, Division of Biology and Medicine, Brown University; Director, Division of Allergy, Rhode Island Hospital, Providence, Rhode Island.

anaphylaxis of insect allergy. An explanation of these results may be based on the point of entry of the allergen into the body. It is possible that the defect in asthma and hay fever lies in the mucous membranes of the upper respiratory tract, the point of entry when an allergen such as ragweed is being inhaled. The point of entry in insect allergy is the subcutaneous tissue where a bee injects the venom. A sting circumvents the defective mucous membrane in atopy. This may explain why atopy does not predispose to the acute anaphylaxis of insect allergy.

We continued to use the insect allergy model for the study of asthma and found that the asthmatic appeared to have a more severe reaction to an insect sting than non-asthmatics. This increased severity of reaction by the asthmatic was manifested by acute bronchospasm. The explanation of why an asthmatic responds to anaphylaxis wit bronchospasm is related to the increased sensitivit of the asthmatic's pulmonary tissue to histamin and perhaps other allergic mediators. Past studi have demonstrated that the asthmatic is very ser sitive to inhaled and intravenous histamine.[4-6] Hi tamine is one of the main products of Ig mediated anaphylaxis, and an increased bloo histamine has been found in generalized anaph lactic reactions. Although the asthmatic does n have an increased risk of developing IgE mediate anaphylaxis, his pulmonary sensitivity to histamin and other mediators of allergy causes him to man fest this anaphylaxis with acute bronchospasm.

Another model of IgE mediated anaphylaxis penicillin allergy. Stember and Levine[7] in 197 found that the frequency of positive skin tests t penicillin products was the same in an atopic an

Figure 1. Mediators for Atopic Asthma



non-atopic segment of a population, which included 1,043 subjects. Unfortunately, one of the authors[8] gave a preliminary report of this study 8 years earlier when only 15 selected, atopic patients were skin tested with penicillin products and most (12) of these patients had positive results. Frequently a smaller, earlier study is quoted while a larger comprehensive study is not. In another study on penicillin allergy, Kern and Wimberley[9] reported that asthmatics may have more severe reactions to penicillin than other individuals. These reports on penicillin allergy are in agreement with our data on insect allergy in that the asthmatic does not appear to have an increased risk of developing anaphylactic reactions. However, when anaphylaxis does occur, the asthmatic has a more severe reaction.

A model for studying non-IgE mediated anaphylactoid reactions in asthma is provided by aspirin intolerance and reactions to intravenous administered radiographic contrast media used for diagnostic purposes. Aspirin intolerance has been well studied. The clinical symptoms produced by adverse reactions to this drug are similar to those produced by insect allergy (Table 1). However, no IgE specific antibody to aspirin has been found in the serum of these patients. For this reason the old term aspirin allergy has been replaced by aspirin intolerance.

Aspirin intolerance is thought to be mediated through the prostaglandin system. Aspirin inhibits the cyclo-oxygenase system, interfering with the conversion of arachidonic acid to endoperoxides, thus blocking the production of PG-F and PG-E. Prostaglandin F causes bronchoconstriction, while PGE produces bronchodilation. A situation may exist in certain asthmatics where an increased ratio of PGF to PGE results in acute bronchospasm. A second mechanism involving the prostaglandin system may also result in acute bronchospasm. Arachidonic acid is the precursor of SRS-A.[10] The interference by aspirin with the metabolism of arachidonic acid may cause an increase in SRS-A, which may directly result in bronchospasm. A third mechanism for aspirin induced bronchospasm involves histamine. Some authors have reported an increased blood histamine level during an anaphylactoid reaction, possibly due to non-specific mast cell degranulation by aspirin.[11] This increased blood histamine may in turn cause an asthmatic to have an acute episode of bronchospasm. Clinically, it has been demonstrated that the asthmatic patient has 10 times the likelihood of developing aspirin intolerance as normal individuals and that the adverse reactions in asthmatics are manifested primarily as acute bronchospasm, (Table 3).[12,13]

Another model for non-IgE mediated reactions in asthmatics is provided by the generalized reactions resulting from intravenously administered radiographic contrast media (RCM). Reactions to RCM are not mediated by any known antibody-antigen reaction. Similarly to aspirin reactions, RCM reactions occur more frequently in asthmatics than in normal individuals.[14] However, the details described in the literature are not explicit enough to determine if the reaction in asthmatics is predominately manifested by acute bronchospasm.

Conclusion

In IgE mediated reactions, such as insect allergy and penicillin allergy, the asthmatic does not have an increased risk of developing adverse reactions. In a non-IgE reactions, such as aspirin intolerance

Table 1. Classification of Bee Sting Reactions

Grade I	— Local reactions only.
Grade II	— Generalized Hives/Angioedema.
Grade III	— Dyspnea or wheezing with or without generalized Hives/Angioedema.
Grade IV	— Syncope with or without generalized Hives/Angioedema or Dyspnea.

Table 2. Frequency of Hymenoptera Allergy in an Atopic and Normal Population[1]

Boy Scouts	Number in Population	Scouts determined to have Hymenoptera Allergy		p Value
		Number	Per Cent	
With asthma and/or hay fever	318	3	0.9	NS†
Without asthma or hay fever	2,639	20	0.8	

†NS — not significant

Table 3. Frequency of Aspirin Intolerance in Various Conditions

Type of Population	Number Studied	Number with Aspirin Intolerance	Per Cent
Chronic Urticaria	577	134	23.2
Asthma	731	28	3.8
Rhinitis	641	9	1.4
Normal	2,592	8	0.3

and generalized reactions to radiographic contrast media, asthmatic patients do have an increased risk of developing generalized reactions. In both the IgE mediated and non-IgE mediated reactions, asthmatic patients have an increased risk of severe generalized reactions, manifested predominately by acute bronchospasm.

References

[1]Settipane GA, Newstead GJ, Boyd GK: Frequency of hymenoptera allergy in an atopic and normal population. J Allergy Clin Immunol 50:146-150, Sep 72.

[2]Settipane GA, Klein DE, Boyd GK: Relationship of atopy and anaphylactic sensitization: A bee sting allergy model. Clin Allergy 8:259-265, May 78.

[3]Settipane GA, Chafee FH, Klein DE, et al: Anaphylactic reactions in asthmatic patients to insect allergy. Clin Allergy, to be published.

[4]Weiss S, Robb GP, Blumgart HL: Velocity of blood flow in health and disease as measured by the effect of histamine on the minute vessels. Am Heart J 4:664-691, Aug 29.

[5]Curry JJ: Action of histamine on the respiratory tract in normal and asthmatic subjects. J Clin Invest 25:785-791, Nov. 46.

[6]Bhat KN, Arroyave CM, Marney SR Jr, et al: Plasma histamine changes during provoked bronchospasm in asthmatic patients. J Allergy Clin Immunol 58:647-656, Dec 76.

[7]Stember RH, Levine BB: Prevalence of allergic diseases, peni hypersensitivity and aeroallergen hypersensitivity in va populations. J Allergy Clin Immunol 51:100, Feb 73.

[8]Hevine BB: Immunologic mechanisms of penicillin allergy haptenic model system for the study of allergic disease of man. Eng J Med 275:1115-1125, 17 Nov 66.

[9]Kern RA, Wimberley NA Jr: Penicillin reactions; their na growing importance, recognition, management and prevention J Med Sci 226:357-375, Oct 53.

[10]Parker CW: Prostaglandins and slow-reacting substance. J Al Clin Immunol 63:1-14, Jan 79.

[11]Stevenson DD, Arroyave CM, Bhat KN, et al: Oral aspirin lenges in asthmatic patients: A study of plasma histamine. Allergy 6:493-505, Sep 76.

[12]Settipane GA, Chafee FH, Klein DE: Aspirin intolerance II. A pective study in an atopic and normal population. J Allergy Immunol 53:200-204, Apr 74.

[13]Settipane RA, Constantine HP, Settipane GA: Aspirin intoler and recurrent urticaria in normal adults and children. All 35:149-154, 1980.

[14]Shehadi WH: Adverse reactions to intravascularly administered trast media. A comprehensive study based on a prospective s Am J Roentgenol Radium Ther Nucl Med 124:142-152, May 7

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ONE SENTENCE ESSAY

To get your teeth fixed in California you have to be an illegal alien . . . Howard Jarvis, of Proposition 13 fame

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Eugene G. Laforet, MD
Robert L. Berger, MD

The use of prosthetic tubes for obstructing carcinoma of the esophagus has a long and checkered but generally honorable history. Such devices have often conferred significant palliation for a disease that even today is almost unmanageable. The currently favored version is the Celestin tube, largely because of its design and material. These attributes, in fact, suggested that its use be extended to esophageal problems other than obstruction carcinoma.[1] It is the purpose of this paper to review our experience with the Celestin tube in such situations.

Material and Method

A Celestin tube was used in the treatment of 20 patients* with complicated esophageal problems. The underlying disease was malignant neoplasm in 9 patients and a non-malignant condition in 11. Fistulas of various types constituted the commonest indication for intubation (14 patients) with obstructions next (6 patients) (Table 1). All tubes were positioned by the pull-through technic utilizing a gastrotomy and concomitant esophagoscopy.

*This series includes 5 patients previously reported.[1]

Presented at the fall meeting of the New England States Chapter, American College of Chest Physicians, Providence, Rhode Island, December 12, 1979.

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Results

No patient died as a direct result of the operative procedure. In all patients with fistulas, esophageal leakage was immediately controlled by the Celestin tube. Those fistulas of non-malignant etiology eventually closed, and the patients recovered. When the fistulas were due to a malignant process, the long-term results were not as satisfactory — one

TABLE 1. Disease Processes in 20 Patients Treated By Intubation

FISTULAS	
esophago-tracheal	
due to carcinoma of lung	1
due to carcinoma of esophagus	3
due to tracheostomy	2
esophago-bronchial	
due to carcinoma of esophagus	1
post-pneumonectomy	1
esophago-pleural	
due to perforation	3
due to rupture	3
OBSTRUCTIONS	
benign stricture	
due to hiatus hernia	1
due to esophago-gastric anastomotic leak	1
extrinsic compression	
due to carcinoma of lung	3
due to carcinoma of breast	1

Figure 1A. Barium swallow (postero-anterior projection) showing flow of contrast medium from esophagus to right lower lobe.

Figure 1B. Lateral view of same.

patient died of underlying disease early in the po operative period, and one with an esophago-tr cheal fistula due to bronchogenic carcinon developed recurrent fistulization. In all instances obstruction, gratifying and permanent relief dysphagia was obtained. Duration of intubati varied with the nature of the underlying diseas the response to treatment, and the condition of t patient. In most of the benign conditions the tu was removed electively, while it was retained i definitely for problems related to malignancy.

Illustrative Cases

Case 1. An 82-year-old man had cough, fev and persistent consolidation in the right low lobe. Barium study of the esophagus demonstrat

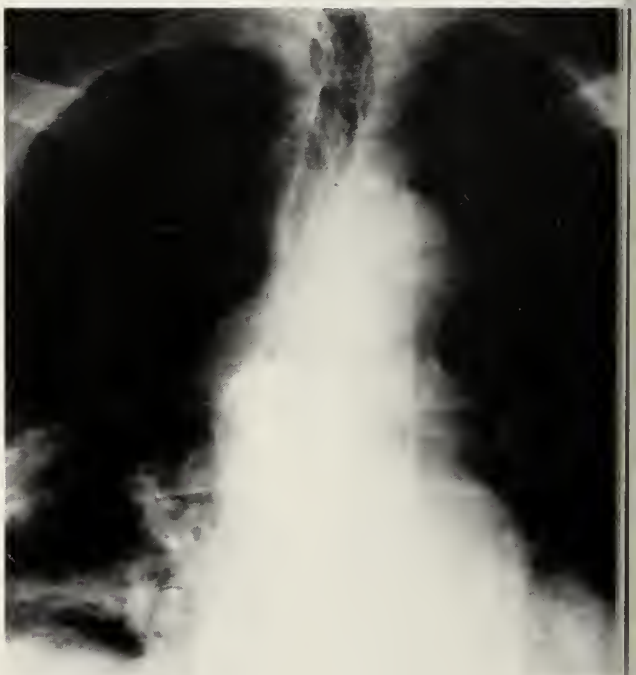

Figure 1C. Barium swallow with Celestin tube in pla showing defunctionalization of fistula tween esophagus and right lower lo Small amount of barium visualized in lu is residue of previous study. Some dence of right lower lobe pneumonitis p sists.

a fistula between that organ and the right lower lobe bronchial tree (Figs. 1A and B). Esophagoscopy and bronchoscopy confirmed the presence of the fistula but its etiology was not determined. A Celestin tube was inserted above the level of the fistula (Fig. 1C) and successfully defunctionalized it. Symptoms regressed and the pneumonitis cleared. The patient was discharged to a nursing home only to return 2 months later because of hematemesis. Although the cause was uncertain, it was thought to be related to the presence of the prosthesis, and the tube was therefore removed. The patient did well for 6 months, when he developed dysphagia, fever, recurrent right lower lobe pneumonitis, and hematemesis. Esophagoscopy at this time showed squamous cell carcinoma of the distal esophagus with bleeding and fistulization to the right lower lobe. A Celestin tube was again inserted with control of the fistula and relief of dysphagia. General deterioration continued, however, and the patient died one month later.

Case 2. A cachectic 66-year-old man with psychiatric problems and severe chronic obstructive lung disease was seen because of almost complete esophageal obstruction secondary to a benign stricture related to hiatus hernia. All efforts at dilatation failed because of his aggressive resistance. Consequently a Celestin tube was inserted. This has continued to function well for the past 5 years, the need for periodic bougienage has been obviated, and excellent nutrition has been maintained.

Case 3. A 70-year-old man with angina on exertion and severe chronic obstructive lung disease was hospitalized because of virtually complete esophageal obstruction. He had undergone esophagogastrectomy and esophagogastrostomy 10 years earlier for an inflammatory stricture erroneously thought to represent a carcinoma. The postoperative course was marred by an anastomotic leak, but the patient made a satisfactory recovery. After several years he began to note dysphagia, but failed to seek help until he could swallow only liquids. A barium study of the esophagus showed a dilated and redundant proximal pouch and a filiform, eccentric stricture (Fig. 2A). Endoscopic dilatation was impossible. Consequently thoracotomy was performed, and the stricture was dilated under direct vision. Reconstruction was not technically feasible. A gastrostomy was established, and a string was positioned in the esophagus. The patient recovered from the thoracotomy and a program of periodic retrograde trans-gastrostomy dilatations with Tucker dilators was begun. A satisfactory esophageal lumen was maintained by this means, but bougienage from above was not possible. In addition, the patient was unable to cope with the social and medical problems occasioned by the gastrostomy and by the string exiting from his nose. Consequently a Celestin tube was inserted and the gastrostomy was closed. The tube (Fig. 2B and C) has continued to function to the patient's satisfaction.

Discussion

It is not proposed that intubation with a Celestin tube supplant the more conventional management

Figure 2A. Barium study demonstrating high grade eccentric stricture at site of intra-thoracic esophagogastrostomy, with markedly dilated and redundant proximal esophageal pouch.

of esophageal fistulas and obstructions when this is feasible. Rather, its use should be reserved for situations urgently requiring treatment, but in which technical difficulty or the condition of the patient militates against the success of an orthodox approach. Its major role, therefore, is likely to be played in the poor risk patient with serious underlying disease and a disastrous complication. Malignant fistulas between esophagus and airway certainly fall in this category, and intubation has proven a valuable technic in their management.[2] In addition, benign esophago-tracheal fistulas — such as occur in the tracheostomized patient requiring prolonged ventilatory support — have responded well to this approach. While direct operative repair remains the optimal therapy for emetogenic rupture of the esophagus when seen early, intubation has been useful when treatment has been delayed.[1] Instrumental perforations also have responded satisfactorily to intubation.[1,3,4]

Dysphagia due to esophageal compression by lymph nodes involved in lung or breast[5] carcinoma is a distressing symptom for which intubation is perhaps the ideal treatment. Dilatation is both hazardous and ineffective in this situation, and systemic anti-tumor therapy is often not applicable. The use of a Celestin tube for benign esophageal strictures is more controversial but may be indicated in specific instances. Longevity of the prosthesis may be a worrisome consideration under

Figure 2B. Barium swallow (postero-anterior projection) with Celestin tube traversing Stricture.

Figure 2C. Lateral view of same.

hese circumstances,[6] although one patient in the present series has retained the Celestin tube for over 5 years without complication. Care in handling the tube during its insertion may prevent structural deterioration in cases of prolonged residence.[7]

The technic of intubation with a Celestin tube is straightforward, but its use for the control of fistulas requires care in positioning so that the upper lip of the prosthesis is maintained proximal to the orifice of the fistula. Since there is rarely a shoulder of tumor to support the flange in such instances, secure distal fixation of the tube to the gastric wall is needed to prevent even minimal aboral migration. Although intubation has involved gastrotomy in all instances comprising the present series, endoscopic insertion alone has been proposed[8] and may help to avoid the morbidity of an abdominal incision in precarious situations.

Conclusions

Intubation with a Celestin tube may be palliative or curative in a variety of complicated esophageal problems. These include malignant or benign esophagorespiratory fistulas, esophageal ruptures and perforations, benign strictures, and esophageal obstruction by extrinsic compression.

References

[1]Berger RL, Donato AT: Treatment of esophageal disruption by intubation. A new method of management. Ann Thorac Surg 13: 27-35, Jan 72.

[2]Lolley DM, Ray JF 3d, Ransdell HT, et al: Management of malignant esophagorespiratory fistula. Ann Thorac Surg 25:516-520, Jun 78.

[3]Sandrasagra FA, English TA, Milstein BB: Esophageal intubation in the management of perforated esophagus with stricture. Ann Thorac Surg 25:399-401, May 78.

[4]Imre J: Plastic tube prosthesis for the surgical treatment of perforations in esophageal strictures. Ann Thorac Surg 15:275-280, Mar 73.

[5]Laforet EG, Kondi ES: Postmastectomy dysphagia. Am J Surg 121:368-373, Apr 71.

[6]Mackenzie I, Whyte AS, Tankel HI: Structural deterioration in celestin tubes. Br J Surg 63:851-852, Nov. 76.

[7]Brown P, Hughes RG: Late complication of endoscopic oesophageal tube insertion. Br Med J 2:970-971, 20 Oct 79.

[8]Heafitz M, Irarrazaval M, Huebl H, et al: A simple technique for intubation of the esophagus for fistulae and obstructions. Chest 65:359-360, Mar 74.

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HOW'S THAT AGAIN? DEPARTMENT

Seen in medical history: Patient had been having pain sparatically for approximately one year.

Current Status of Cardiac Pacing

Recent Advances Provide Hope in the Quest for a Perfect Pacemaker

Phillip Varriale, MD

The application of transthoracic electrical discharge for successful resuscitation of a heart in ventricular standstill by Zoll in 1952 ushered in the modern era of clinical cardiac pacing. With the implantation of the first successful long-term pacemaker in 1960 by Chardack, the scope and clinical application of pacing has evolved at an awesome rate. Today the physician has at his disposal a wide variety of sophisticated and specialized pacemaker devices that are reliable and effective. In large measure, this has occurred with the spectacular advances in electrode design, power sources, and circuitry. Concomitantly, rapid expansion has emerged in the indications for pacing, techniques for pacing, hemodynamic benefits, and the longevity of the pacemaker system.

Approximately one-half million people in the United States have had an implantable pacemaker since 1960, and 270,000 are still living. The United States has the highest rate of new pacemaker implants in the world — approximately 66,000 each year or 308 per million.[1]

As for pacemaker patient survival, a survey covering the period 1962 and 1976 indicates that longevity following implant is most favorable for the younger patient and less for the older. On the average, 60 per cent survive at least 5 years and 40 per cent 10 years.[2] The life expectancy of pacemaker patients when compared to that of the general population is almost identical and perhaps even better.

Improvements in Batteries and Circuitry

Pacemaker electronic circuitry has improved in reliability despite increased complexity. This trend will continue due to the emergence of programmable and more sophisticated physiologic pacing systems. Initial pacemakers characterized by discrete components that include transistors, resistors, capacitors, reed switches, and inductor coils with cumbersome interconnections have been replaced by integrated circuits of reduced size and increased functional capability. Advanced construction techniques and packaging in the pulse generator, referred to as a hybrid circuit, may now be contained on a substrate or small silicon chip of several millimeters' dimension and hermetically sealed.

During the first 15 years of cardiac pacing, nearly all pacemakers were powered by a mercuric oxide-zinc battery consisting of 4 to 6 cells in series. Although mercury-zinc became the standard of the industry, this energy source, from the beginning, was plagued by useful energy loss through self-discharge, a disturbing incidence of premature battery failure with rapid decay, and an incompatibility with hermeticity which predisposed to a higher rate of component or circuitry failure.[3]

In 1972, Wilson Greatbatch introduced the lithium battery as a new energy source for cardiac pacing. Within a brief period of 5 years, the unexcelled high performance of the lithium cel

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stablished this power source as the "undisputed aster", and its high suitability and current usage as in effect dominated the pacemaker industry.

Lithium, an active alkali metal, serves as the node and can react chemically with a variety of alogen cathodes to form a solid or liquid electro-te conductive system without discharging a aseous emission, as does the mercury-zinc cell, to enerate a high cell voltage (2.8V) and useful nergy. The lithium iodine system, most commonly sed today, forms a solid electrolyte that increases ell resistance accompanied by a linear but slow oltage decline which is sufficiently prolonged and redictable before termination of useful energy. bsence of gaseous products permits hermeticity, nd this sealed enclosure further protects circuit erformance. Component failure is unusually low nd reported to be less than 0.3 per cent per year. attery failures have been exceedingly rare, and nergy discharge for effective pacing has an esti-ated longevity between 6 and 10 years.[3]

Nuclear pacemakers, almost exclusively pluto-ium 238, are safe, reliable, and effective with the ongest theoretical performance. Rigid gov-rnmental regulations and compliance and its igh cost have discouraged wide acceptance of this nergy source. Presently the nuclear pacemaker is sed in a fraction of one per cent of the total world acer implants.

Based upon the impressive reliability and lon-evity of the lithium power source, the modern ulse generator is no longer a significant pacing ystem problem. Pacemaker re-operations for attery exhaustion have declined from 60 to 80 per ent only a few years ago to less than 40 per cent nd are due principally to the manifest failure of ercury-zinc units previously implanted.[4]

The electrode has emerged as the weakest link in ne pacing system and is today the leading failure echanism. Most surgical interventions are now erformed for electrode-related problems.

The transvenous method, using a variety of ndocardial lead designs, remains the dominant acing mode and represents approximately 90 per ent of all pacemaker implantation. Lead failure ssociated with transvenous pacing occurs with a te that varies from under 5 per cent to over 20 er cent during the first year post-implantation, nd most are manifest within the first month.

Conventional endocardial leads terminate in a lindrical or spherical electrode tip with or ithout a flange configuration and are considered passive leads", since adherence to the apical right ntricular position is maintained by a loose en-apment of the electrode in the trabeculae, axial pressure exerted by the attached lead wire, and a time-dependent fibrous tissue reaction around the electrode.[5]

New Leads

"Active leads" have recently been introduced in an attempt further to reduce displacement, the single most frequent electrode malfunction. These innovative lead designs incorporate barbs, corkscrews, nylon bristles, or fine metal wires that are ejected through the electrode, once satisfactorily positioned, to grasp the endomyocardium.

A new design characterized as a tine-tipped electrode considered a "passive-active lead" appears to provide firmer entrapment of the electrode within the trabeculae and is presently proclaimed as an ideal lead with early reported displacement rates of 0 to 5 per cent.[6] Notwithstanding these advanced lead designs, meticulous technique during lead placement and the competence and expertise of the operator must be recognized as equally important factors in avoiding this failure mechanism.

Lead longevity and the ever-present wire conductor fracture of 1-2 per cent has been further improved by new conductor technology that uses a multifilar coil configuration of space wound multi-stranded nickel alloy wire. Laboratory tests support increased flex life for the multifilar coil design as compared to the conventional single filament coil conductor.

The relationship of improved stimulation thresholds and electrodes of reduced surface area has been recognized since the early days of pacing. Conventional stimulating electrodes have a surface area ranging between 5 and 12mm^2 and most 8 to 12mm^2. These electrodes of reduced surface area decrease current threshold and current drain, and enhance energy efficiency.[7] A recent electrode design characterized by a ring-tip configuration of 8mm^2 is presently considered "optimal", since it provides high current density to the endomyocardium for stimulation along its area of curvature without compromising the sensing signal.

It is important to emphasize that proper apposition of the electrode to the endocardium during lead placement be firmly established by fluoroscopic control and precise and meticulous intraoperative electrical testing procedures, preferably using an appropriate Pacing System Analyzer to determine both the minimal voltage requirement and simultaneous current pulse amplitude for consistent pacing at the pulse width corresponding to that of the implantable pulse generator. A satisfactory electrode site is also established by an electrographic recording of the cardiac signal for

sensing using a physiologic oscilloscopic instrument to confirm an adequate signal amplitude and slew rate.[8]

Types of Pacemakers

Ventricular demand pacing (VVI) is the dominant pacemaker modality used today for a variety of symptomatic and asymptomatic bradyarrhythmias due to sick sinus syndrome (SSS) or incomplete or complete atrioventricular (AV) block. Nonetheless, it has become increasingly evident that this modality of pacing is basically non-physiologic, since it creates dissociation of the atria and ventricles and loss of normal atrio-ventricular synchronous contraction. Depending on the state of ventricular function and level of left ventricular filling pressure, the atrial contribution may augment cardiac output from 5 to 35 per cent. Contrary to popular belief, the hemodynamic benefits of the atrial transport mechanism appear to be maximal in patients with normal filling pressure and less for those with underlying cardiac disease.[9] The importance of AV synchronous contraction in enhancing cardiac output has been well documented in patients with acute myocardial infarction and open-heart surgery postoperatively.[10]

Subsequent to permanent ventricular pacing, many elderly patients may later develop congestive heart failure for the first time or develop manifestations of reduced cardiac output such as hypotension or disabling lassitude; rarely, orthostatic hypotension may appear. A dramatic example of this phenomenon may occur when ventricular pacing produces ventricular reciprocal beats due to retrograde atrial activation. The reciprocal beat is mechanically ineffective, and the pacing cycle further prolonged to yield an uncorrected bradycardia.

Additionally, underlying atrial or ventricular arrhythmias that were manifest before ventricular pacing may relentlessly persist and continue to plague the patient despite conventional drug therapy.

Atrial and dual-chamber pacemaker devices have been introduced recently applied increasingly to circumvent these problems. They are designed primarily to restore or establish AV synchrony and are therefore aptly described as physiologic pacemakers. For many patients who require pacing, these pacemaker modalities may not only confer an improved hemodynamic state through an enhanced cardiac output, but provide relatively effective control of existing atrial or ventricular arrhythmias or both without the need for drug therapy.[11]

Atrial demand pacing (AAI or AAT) is particularly applicable to patients with sick sinus syndrome with intact AV conduction. This requirement should be confirmed preoperatively by placement of a temporary lead into the right atrium to document normal AV conduction with incremental atrial pacing to rates of 130 pulses/min. Patients with bifascicular block and the risk of future AV block or those who show prolongation of the HV interval on His bundle study should not be considered for permanent atrial pacing. Atrial overdrive pacing using a permanent atrial demand pacemaker, moreover, is often completely effective in the suppression of certain resistant supra-ventricular and ventricular arrhythmias that occur in the setting of sick sinus syndrome.[12]

Endocardial atrial leads may be placed in either the coronary sinus or right atrial appendage. A tined J-atrial lead has recently been introduced to provide a more stable and secure electrode position within the appendage — an indispensable requirement for all physiologic pacing systems that necessarily utilize an atrial electrode.[13]

Despite this advantageous lead design, displacements have not been infrequent and range from 10 to 30 per cent and are more apt to occur in the immediate post-implant period. Effective and secure placement of this atrial lead requires careful technique and considerable expertise, and a "learning curve" will be evident for those physicians who begin to apply this lead.

At the present time, the most frequently utilized dual-chamber physiologic pacing device is the bifocal or AV Sequential ventricular demand pacemaker (DVI).[14] It requires a bipolar configuration for both the atrial and ventricular leads except for the new Intermedics Model, and sensing occurs exclusively through the ventricular lead. A pace pulse is emitted to stimulate the atrium at a shorter escape interval than the stimulating pulse to the ventricle, and the difference in time determines the AV delay or PR interval. Both the rate and AV delay interval may be programmed non-invasively by an external programmer.

The AV Sequential pacemaker is applicable to all patients with SSS with or without AV conduction disease and all varieties of AV block. It is a highly effective pacing technique, moreover, for the control of many resistant atrial and ventricular arrhythmias that coexist with SSS or AV block. Suppression of ventricular premature beats with a long compensatory pause or intermittent ventricular tachycardia can often be effectively established. Many AV nodal reentrant tachycardias or AV reciprocating tachycardia

using an accessory AV pathway may be readily interrupted and controlled with conventional pacing rates and the simple expedient of adjusting the AV delay to a short interval.

New Developments

The application of implantable pacemakers for the management and conversion of certain chronic, recurrent and drug-resistant supraventricular or ventricular tachycardias related to a reentrant mechanism is an emerging discipline. A Rapid Atrial Stimulation pacing device for overdrive suppression of reentrant supra-ventricular tachycardia, developed by Medtronics, provides bursts of rapid atrial stimulation to the atrial myocardium via a bipolar lead positioned pervenously into the right atrial appendage or secured epicardially at thoracotomy. The pacemaker is a patient-activated radiofrequency triggered system that consists of an implantable receiver and external transmitter that provides an adjustable pacing rate up to 400 pulses/min. The pacemaker receives its power from the hand-held, patient-triggered transmitter through radio-frequency coupling.[15,16] Prior sophisticated electrophysiologic studies are mandatory to determine the efficacy and safety of this pacing technique. Therapeutic pacing is not indicated in reentrant supraventricular tachyarrhythmias if atrial fibrillation with an excessive ventricular response incident to accelerated AV conduction is induced during rapid atrial stimulation.

Termination of chronic, recurrent, life-threatening, drug-refractory ventricular tachycardia with bursts of rapid ventricular pacing at rates between 180 and 300 pulses/min for several seconds duration has proven successful in a small number of patients reported in several studies.

The first permanent implantable automatic "anti-tachycardia" pacing device for termination of ventricular tachycardia was recently released by Intermedics for investigational use. This innovative pacemaker, Cyber-Tach-60, has a dual modal function. It operates in the ventricular demand mode VVI at a rate of 60 or 80 pulses/min and also has a Tachycardia Response mode capable of emitting bursts of rapid stimuli for a prescribed duration when a tachycardia is detected. This pacemaker is programmed to detect any tachycardia either above 137 or 180 BPM and emits bursts of stimuli at a programmed duration after 8 consecutive tachycardia beats are sensed. The burst rate may be programmed between 180 and 720 pulses/min and the burst duration 1.3 to 5.3 seconds.

The emergence of a variety of new multi-parameter programmable pacemakers appears to be another recent technological triumph which promises considerable clinical utility now and in the immediate future. Non-invasive programming of one or more parameters of pacemaker function may be changed by application of an appropriately selected external programmer. A special circuit within the pulse generator responds to the command transmitted by the programmer in the form of pulsed radiofrequency signals transmitted in a coded sequence, timing, and amplitude known as a "data bit". The entire procedure can be performed in a fraction of a second.

Depending on the manufacturer's specifications, the pacing rate can be adjusted from 30 to 130 pulses/min. A programmed rate change may be used, for example, to achieve a maximal cardiac output in patients with congestive heart failure or mitral valve disease or for the overdrive suppression of certain ectopic arrhythmic disturbances. Sensitivity programmability can modify the characteristics of the sensing amplifier to increase its sensitivity for low amplitude cardiac signals or conversely eliminate oversensing from high amplitude myopotentials or electromagnetic interference. Manipulation of the delivered pulse energy may be mediated by changes in the pulse width or pulse amplitude to maintain consistent pacing. On the other hand, the pulse energy may be reduced to eliminate phrenic nerve or muscle stimulation or to extend battery life.

Admittedly, great progress is being made in the development of pacemaker technology and its application to clinical events and in the quest for the "ideal pacemaker." Although the decade that began with the epochal contribution of Zoll in 1952 and ended with the first implantable pervenous pacing system has been called the Golden Decade, the years that lie immediately ahead may indeed be the Golden Age of Pacing.

References

[1]Proceedings of the VIth world symposium on cardiac pacing. World Survey on Cardiac Pacing, section 41, 1979.

[2]Furman S, Whitman R: Cardiac pacing and pacemakers IX. Statistical analysis of pacemaker data. Am Heart J 95:115-125, Jan 78.

[3]Parsonnet V: Cardiac pacing and pacemakers VII. Power sources for implantable pacemakers. Part I. Am Heart J 94:517-528, Oct 77.

[4]Parsonnet V: Cardiac pacing and pacemakers VII. Power sources for implantable pacemakers. Part II. Am Heart J 94:658-664, Nov 77.

[5]Furman S. Pannizzo F, Campo I: Comparison of active and passive adhering leads for endocardial pacing. Pace 2:417-427, Jul/Aug 79.

[6]Product performance verification report for Medtronic transvenous ring-tipped, tined ventricular leads, models 6961 and 6962. Medtronic, Inc. 1978.

[7]Furman S, Parker B, Escher DJ: Decreasing electrode size and increasing efficiency of cardiac stimulation. Surg Res 11: 105-110, Mar 71.

[8]Furman S, Hurzeler P, DeCaprio V: Cardiac pacing and pacemakers 111. Sensing the cardiac electrogram. Am Heart J 93:794-801, Jun 77.
[9]Greenberg B, Chatterjee K, Parmley WW, et al: The influence of left ventricular filling pressure on atrial contribution to cardiac output. Am Heart J 98:742-751, Dec 79.
[10]Hartzler GO, Maloney JD, Curtis JJ, et al: Hemodynamic benefits of atrioventricular sequential pacing after cardiac surgery. Am J Cardiol 40:232-236, Aug 77.
[11]Dreifus LS, Berkovits BV, Kimibiris D, et al: Use of atrial and bifocal cardiac pacemakers for treating resistant dysrhythmias. Eur J Cardiol 3:257-266, Dec 75.
[12]Moss AJ: Therapeutic uses of permanent pervenous atrial pacemakers: A review. J Electrocardiol 8:373-380, 1975.
[13]Citron P, Smyth NP, Kleinert M, et al: Clinical experience with a new transvenous atrial lead. Chest 73:193-197, Feb 78.
[14]Levy S, Gerard R, Jausseran J, et al: Long-term results of permanent atrioventricular sequential demand pacing. Pace 2:175-182, Mar/Apr 79.
[15]Kahn A, Morris JJ, Citron P: Patient-initiated rapid atrial pacing to manage supraventricular tachycardia. Am J Cardiol 38:200-204, Aug 76.
[16]Peters RW, Shafton E, Frank S, et al: Radiofrequency-triggered pacemakers: Uses and limitations. A long-term study. Ann Intern Med 88:17-22, Jan 78.

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THE SOCIETY'S FIRST FEMALE FELLOW

In these days of ERA it seems appropriate to remember the Society's first female Fellow. Doctor Ely presented Anita Elizabeth Tyng for membership, without reference to Censors, December 21, 1870, but his motion was lost as the vote, 24 yeas and 15 nays, was less than the two thirds necessary. On December 18, 1872, the Censors approved her admission, leading to an "animated discussion" and the appointment of a committee of one, Doctor Edwin M. Snow, to consider the legality of the matter. He reported, March 19, 1873, that "Miss Tyng had been legally elected".

She was appointed to read a paper in 1874 and did so; "an able and interesting paper on Eclampsia Puerperalis *which was received with applause". It was published in our Transactions as was her* Removal of Both Ovaries for Relief of Fibroid Tumor of the Uterus *in which she described the surgical procedure and the fact that "all present had carefully bathed with carbolized water and wore fresh, clean calico dresses". This article has a lengthy bibliography; the first in the Society's Transactions.*

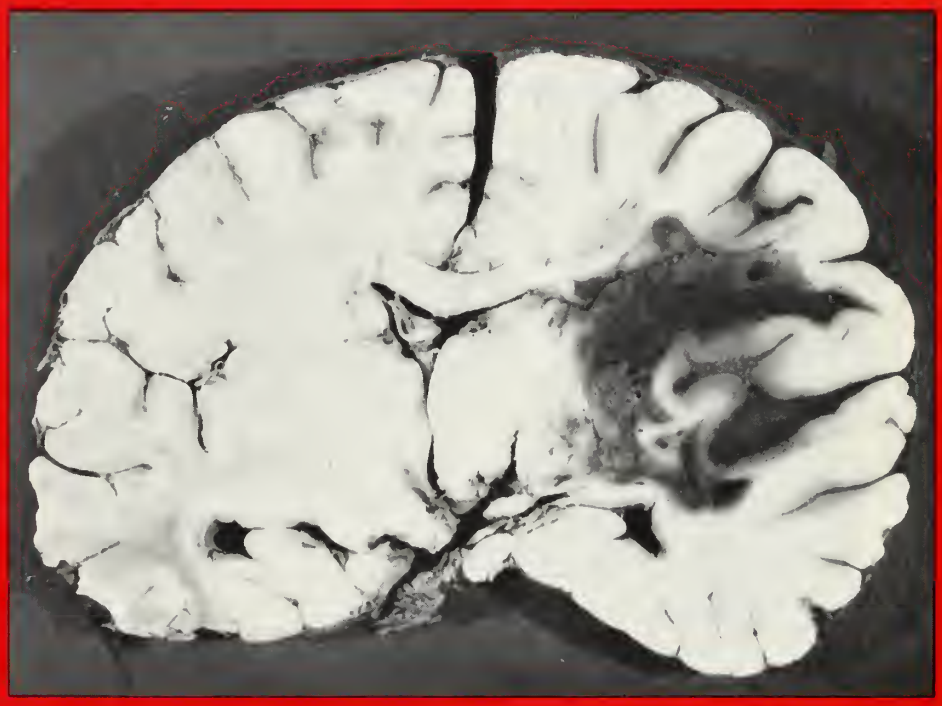
Doctor Tyng was an active member of both the Rhode Island Medical Society and the Providence Medical Association, attending meetings faithfully, presenting cases, and taking part in discussions. Her membership in the Society continued even after she became resident surgeon and superintendent of the Woman's Hospital in Philadelphia in 1883. Three of the four times she was appointed a delegate to the American Medical Association occurred after she left Rhode Island. Doctor Hersey mentions her interest in his Library and her help in finding early volumes of the American Journal of Obstetrics.

In a presidential address, Doctor Robert F. Noyes said: ". . . the Rhode Island Medical Society performed a most noble act several years ago, one for which it has never been sorry, but always proud, when it . . . admitted to fellowship a lady practitioner, who with womanly, yet with determined knock, had indicated her desire for admission. Since that time the Society has learned, and now appreciates, that in the higher realm of intellectual attainment, in the ability to practice medicine and surgery, there is no distinction of gender."

From Helen E. De Jong, Librarian Emeritus

November 1980
Volume 63, Number 11

Rhode Island Medical Journal



tracerebral Hemorrhage
Rare Complication Of TPN

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CONTRIBUTIONS

Intracerebral Hemorrhage Associated with Total Parenteral Nutrition and Anticoagulation

Laboratory Testing in Teaching Hospitals: Impact on the Cost of Health Care

The Effects of Modern Therapeutics on the Human Gene Pool

PRESIDENT'S CORNER

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NEWSLETTER

half-life

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Ensures smooth therapeutic effect even if a dose is missed The relatively longer half-life of Valium®(diazepam/Roche) has important clinical and pharmacological implications. Steady-state levels generally are reached within 5-7 days with no further accumulation. At this plateau, the patient benefits from the consistent, steady response you expect. Sharp blood level variations, frequently attributed to agents with a short half-life, do not appear with Valium.

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*Sellers EM: *Drug Metab Rev* 8(1):5-11, 1978

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Indications: Management of anxiety disorders, or short-term relief of symptoms of anxiety, symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal, adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy)
The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.
Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma, may be used in patients with open angle glaucoma who are receiving appropriate therapy.
Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.
***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**
Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.
Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice, periodic blood counts and liver function tests advisable during long-term therapy.

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November 1980
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hode Island Medical Journal

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WARNINGS:

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Use in ambulatory patients: Empirin with Codeine may impair the mental and/or physical abilities require performance of potentially hazardous tasks such as driving a car or operating machinery. The patient using this d be cautioned accordingly.

Interaction with other central nervous system (CNS) depressants: Patients receiving other narcotic analgesics anesthetics, phenothiazines, other tranquilizers, sedative-hypnotics, or other CNS depressants (including alcohol tantly with Empirin with Codeine may exhibit an additive CNS depression. When such combined therapy is contem dose of one or both agents should be reduced.

Use in pregnancy: Safe use in pregnancy has not been established relative to possible adverse effects on fetal de Therefore, Empirin with Codeine should not be used in pregnant women unless, in the judgment of the physician, the benefits outweigh the possible hazards.

PRECAUTIONS:

Head injury and increased intracranial pressure: The respiratory depressant effects of narcotics and their elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracrania a pre-existing increase in intracranial pressure. Furthermore, narcotics produce adverse reactions which may ob clinical course of patients with head injuries.

Acute abdominal conditions: The administration of Empirin with Codeine or other narcotics may obscure the di clinical course in patients with acute abdominal conditions.

Allergic: Precautions should be taken in administering salicylates to persons with known allergies; patients polyps are more likely to be hypersensitive to aspirin.

Special risk patients: Empirin with Codeine should be given with caution to certain patients such as the debilitated, and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease hypertrophy or urethral stricture, peptic ulcer, or coagulation disorders.

ADVERSE REACTIONS: The most frequently observed adverse reactions to codeine include light-headedness sedation, nausea and vomiting. These effects seem to be more prominent in ambulatory than in nonambulatory pa some of these adverse reactions may be alleviated if the patient lies down. Other adverse reactions include dysphoria, constipation, and pruritus.

The most frequently observed reactions to aspirin include headache, vertigo, ringing in the ears, mental confusi ness, sweating, thirst, nausea, and vomiting. Occasional patients experience gastric irritation and bleeding w Some patients are unable to take salicylates without developing nausea and vomiting. Hypersensitivity may be ma a skin rash or even an anaphylactic reaction. With these exceptions, most of the side effects occur after repeated tion of large doses.

DOSAGE AND ADMINISTRATION: Dosage should be adjusted according to the severity of the pain and the respo patient. It may occasionally be necessary to exceed the usual dosage recommended below in cases of more severe those patients who have become tolerant to the analgesic effect of narcotics. Empirin with Codeine is given orally adult dose for Empirin with Codeine No. 2 and No. 3 is one or two tablets every four hours as required. The usual for Empirin with Codeine No. 4 is one tablet every four hours as required.

DRUG INTERACTIONS: The CNS depressant effects of Empirin with Codeine may be additive with that of other CNS depressants. See WARNINGS.

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Pneumococcal Pneumonia— It Demands Management

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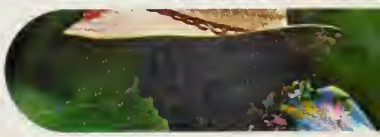

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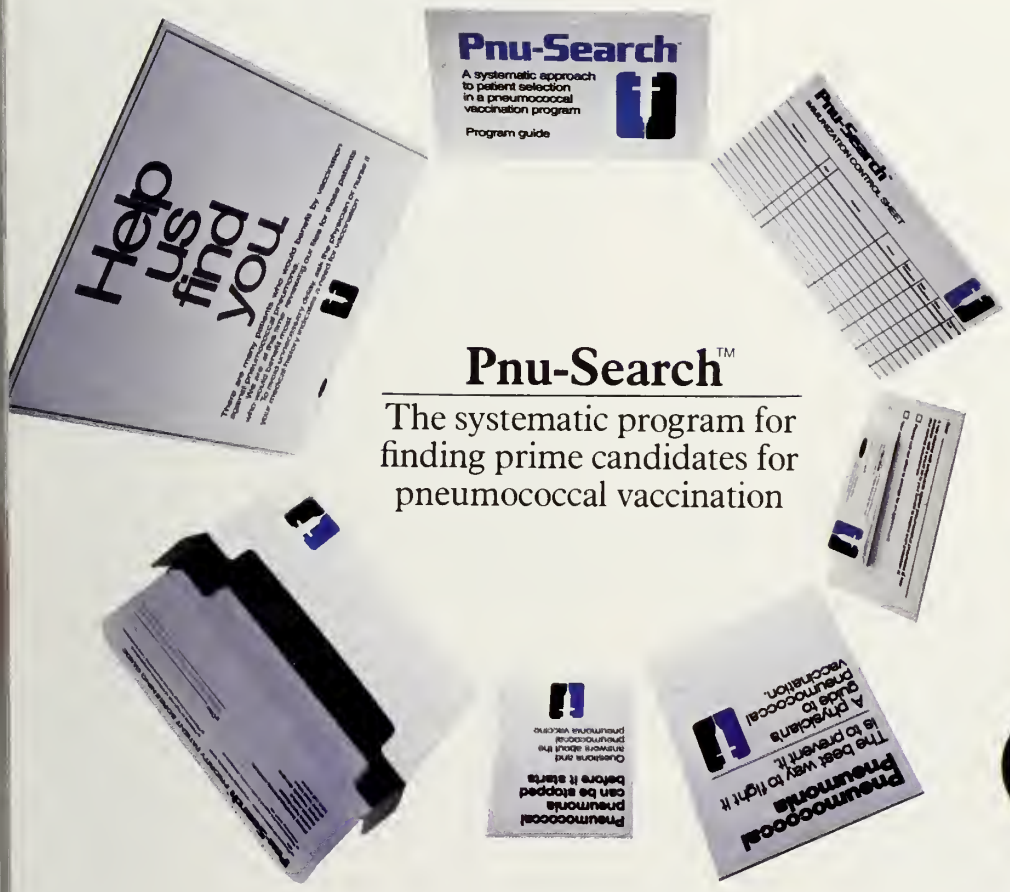
Pnu-Search
A systematic approach to patient selection in a pneumococcal vaccination program
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- Immunization control sheet, for listing of patients to be contacted
- A poster for your waiting room
- Patient appointment postcards for contacting patients and confirming appointments
- A question-and-answer booklet on pneumococcal pneumonia immunization
- Patient education booklets
- Patient record labels

From Lederle – A Complete System for the Management of Pneumococcal Pneumonia

Please see following page for brief summary of prescribing information.

References: 1. *Hospital Update,* A Comprehensive Review of the Growing Institutional Market 1965-1977, *Drug Therapy,* NY pp 26-27. **2.** Rissing JP, Moore WL.: *Mod Med* Jan. 30-Feb. 15, 1979, pp 64-83. **3.** Using the new pneumococcal vaccine. Prepared in consultation with Austrian R, Robbins JB: *Patient Care,* April 15, 1978, pp 20-37. **4.** Smit P: *JAMA* 238:2613, 1977. **5.** Krause JE, Mufson MA: *Am J Epidemiol* 104:348, 1976. **6.** Hoeprich PD: *Hosp Pract* 14:69, March 1979.

PNU-IMUNE®
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INDICATIONS:
PNU-IMUNE is indicated for immunization against pneumococcal disease caused by those pneumococcal types included in the vaccine. See package circular for full details.

Simultaneous administration of pneumococcal polysaccharide vaccine and whole-virus influenza vaccine has been found to give satisfactory antibody response without increasing the incidence of side effects. Although not yet studied, simultaneous administration of the pneumococcal vaccine and split-virus influenza vaccine may also be expected to yield satisfactory results.

CONTRAINDICATIONS:
Pregnancy: Safety, immunogenicity and efficacy of the vaccine in pregnancy has not been established, and vaccination is not recommended during pregnancy. ***Children Below 2 Years of Age:*** Children in this age group respond poorly to the current vaccine, and vaccination of children in this age group ***should not be undertaken.*** ***Hypersensitivity:*** Known hypersensitivity to any component of the vaccine, including hypersensitivity to thimerosal. Remedial measures for anaphylactoid reactions, including epinephrine injection (1:1000), must be available for immediate use.

WARNINGS:
PNU-IMUNE is not an effective agent for prophylaxis against pneumococcal disease caused by types not present in the vaccine. The vaccine may not be effective in patients undergoing treatment causing therapeutic suppression of the immune-response system. Patients who have received extensive chemotherapy and/or splenectomy for the treatment of Hodgkin's Disease have been shown to have an impaired serum antibody response to pneumococcal vaccine.

PRECAUTIONS:
The vaccine should be injected deeply subcutaneously or intramuscularly. Do not inject intravenously. In the presence of any febrile respiratory illness or other active infection, the vaccine should not be used. The parenteral administration of any biological product should be surrounded by every known precaution for the prevention and arrest of allergic and other untoward reactions. A separate heat-sterilized syringe and needle or a new disposable equivalent should be used for each patient to prevent transmission of hepatitis B or other infectious agents. Patients having had episodes of pneumococcal pneumonia or other pneumococcal infection in the preceding three years may have high levels of pre-existing pneumococcal antibodies, which may result in increased reactions to PNU-IMUNE, mostly local but occasionally systemic. Exercise caution if such patients are considered for vaccination with PNU-IMUNE. Revaccination should not be considered at less than 3-year intervals, since protective antibody levels are believed to persist for substantial periods in most vaccinated persons. Revaccination before 3 years may result in more frequent and severe local reactions at the site of injection, especially in persons who have retained high antibody levels.

ADVERSE REACTIONS:
Adverse reactions with PNU-IMUNE are relatively few, not serious, and of short duration, consisting for the most part of local reaction at injection site within 3 days after vaccination, low-grade fever (less than 100°F), usually confined to the 24-hour period following vaccination. Although rare, fever over 102°F and marked local swelling have been reported with pneumococcal polysaccharide vaccine. Reactions of greater severity or extent are unusual. Rarely, anaphylactoid reactions have been reported.

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lewsletter

Peter L. Mathieu, Jr., MD, Editor
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ew Directions for
ledical Care

hard Wong, MD*

ysicians need to be involved in health planning on a ionwide, statewide and local basis. This was the ssage of a recent two-day seminar, New Directions Medical Care — A Challenge for the 80s, in which ysicians, lawyers, hospital administrators and spital planners discussed their impressions of sent-day medicine and their prognostications for coming decade.

H. Thomas Ballantine, Jr., MD, AMA trustee, was the note speaker. He emphasized that a major innova- in the delivery of health care in the coming decade be the rationing of health care. The total expendi- e for health care now approximates $212.2 billion a r. Health planning will have to deal with the mma of finite resources as well as the associated blems of availability of services, cost effectiveness reatments, and preserving high quality care. To do physicians should be represented on hospital rds of trustees, hospital planning committees, and pital budget committees.

ccording to Robert J. Rubin, MD, a member of the ncil on Legislation for the Massachusetts Medical iety, physicians are involved in three ways in the nation and implementation of health policy: as (1) isors, (2) supplicants, and (3) adversaries. The phy- an with increasing frequency is thrust into the role supplicant and adversary. However, according to in, it is the role of learned advisor which physi- ns should strengthen and insist upon.

he all-too-common situation of having to protest an avorable bill or agency generated health plan at the venth hour should be avoided by physician involve- nt in the planning of legislation and governmental ulation from its conception. Failing to get results n this process, input should be directed to the ncy that will administer the policy, so that the itive aspects of the legislation can be implemented not subverted by faulty interpretation of staff.

Ir. Jack C. Wood, a senior law partner in the ston law firm of Wood, Lucksinger and Epstein, dressed the seminar in strong opposition to the ent regulatory climate, a "regulatory swamp", ch will become infinitely worse in the next decade. said that the inevitable superimposing of layers of ulations will demand a bureaucracy for administra- as well as lawyers and CPAs for implementation nd less money for actual delivery of medical care.

Wood predicts that there will be a move toward regulation of individual providers' capital expenditures to a degree that is unthinkable today. He feels that state health plans as the framework upon which regulation and implementation will rest is but another regulatory layer which separates the patient from the physician, and will divert funds from direct patient care.

(Continued next page)

RIMS • Membership Count • RIMS
(as of September 30, 1980)

Total RIMS members 1376
Total AMA members 815
New RIMS members 23
(since August 31, 1980)

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Ronald A. Yankee, MD
Marvin S. Wasser, MD
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Supplement to:
Rhode Island Medical Society Appointed Committees 1980-1981
(Rhode Island Medical Journal, July 1980)

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New Directions for Medical Care *(continued)*

Also, Wood recommends that hospital based providers avoid combined billing to prevent the trend toward hospitals' usurping the individual physician's privilege of collecting fee for service. He made special note of this as relates to pathologists. Often we become aware of these regulations after they are implemented and begin to adversely affect us adversely. We need to support our lobbyists and our medical societies. He maintains that the best prepared and strongest advocate will prevail.

Health planner and Executive Vice President of M. Boston Associates, Inc., David M. Hunter, outlined the major health planning issues of the 1980s: control of supply and distribution of physicians, evolution of IPAs, HMOs, and the changing role of ERs, ambulatory care, planning with awareness of impending regulation, ancillary medical fields, consolidation of hospital services, cost containment, geriatric care, and wellness and preventative care.

The six main avenues of future regulation were discussed by David M. Kinzer, president of the Massachusetts Hospital Association: fiscal controls, controls on facilities and services expansion, controls on utilization, controls on demand for services, control of health manpower supply, and control on "quality of services".

As regulation becomes better and more pervasive, it will cost more and the level of expertise and performance of these agencies which will make virtual life and death decisions, will need to be appreciated by all. The framework for regulation will be state health plans, but these assume territorial franchises, ie, everything is dictated by a map. No consideration is given to existing referral patterns or patterns of health care. No consideration is given to the needs of individual patients, and existing hospitals with preexisting patient populations which may or may not conform to geographic guidelines.

The new direction in medical care is that of planning forced by regulation. The dilemma that is created by this is the apparent choice between cost cutting versus improved quality of care. Are they mutually exclusive? The message for physicians is for them to be involved in the politics of medicine — support your societies and politicize your patients. Regular seminars and formal medical school training relating to regulation should be encouraged. It will be increasingly important for neophyte physicians to be informed of the rules of the game that they will be expected to play. ■

RIMS Christmas Party

Presentation of District Society Charters . . . Past Presidents Gallery . . . Delicious Refreshments

December 16, 1980
6:00 pm

Home Care Programs

Charles L. Hill, MD*
Executive Vice President

On the assumption that the physician still generate most of the costs of medical care, it would seem appro priate to develop some innovative mechanisms t reduce costs and yet uphold or improve the quality c that care. I believe that a continuum of care in Rhod Island generated by physicians, hospitals, and hospit medical staffs merits further investigation. The perso ality and conservatism of the individual physician ma preclude willingness to expose his patient to a ne mode of therapy or long-term care. However, if it were part of the hospital with which he is affiliated, then would be more available and acceptable to him.

Home Care Programs in this state are too few and a not well enough accepted to be utilized to any signi cant extent. It would seem appropriate for providers t explore ways to integrate a system which starts wi the primary care of the physician, and continues in the hospital with which he is affiliated for seconda and tertiary care. As a dividend of such a syste physicians and house staff would become more awa of the costs of the in-patient care. Also, there would b a string of nursing homes either formally or informal associated with the hospital or group of hospital which would provide skilled or intermediate care. Lik wise, the Home Care Program would be identified wi the parent institution.

Presently, there is no sense of continuity, and c tainly not enough publicity reaching the practici physician to make Home Care Programs a genera accepted part of treatment plans. Health and co munity planning in a vacuum which excludes the mo vations of the individuals participating in the system unrealistic. Therefore, the psychology of the provid and the consumer must be our first consideration.

Golf Tournament Time Again

Howard E. Lawton

The Providence Medical Association Annual Golf To nament and Dinner was held on Wednesday, Septemb 17, 1980 at the Rhode Island Country Club. A lar group of physicians and their guests enjoyed the da outing followed by a gourmet dinner. After dinn prizes were presented by Dr. Robert W. Rieme director and toastmaster for the affair, to Dr. Joseph Lambiase* (overall low gross), Dr. Frank Catanza (low), and Dr. James Hanson* (kicker). Short talks we given by Dr. Peter L. Mathieu, Jr.,* President of t Rhode Island Medical Society, and Dr. Daniel Moo Jr.,* President of the Providence Medical Associatio

Arrangements were handled by Howard E. Lawt Assistant Executive Director, and the staff.

nterviews of the Month:

J Robert Bowen, MD*
Aartin Felder, MD*

Ds. J. Robert Bowen and Martin Felder are the presi-dnts of the Providence Surgical Society and the Rode Island Chapter, American College of Surgeons, spectively. This month's column is a "double feature" bout the two doctors, their views, and their interests.

Dr. Martin Felder, President of the Rhode Island Capter, American College of Surgeons, Director of the Division of General Surgery and Acting Associate Surgon-in-Chief of the Department of Surgery at The Miam Hospital, and Clinical Associate Professor of Sgery in the Brown University Program in Medicine, is lo Senior Surgical Consultant to the Rhode Island Goup Health Association (RIGHA). In all of these activi-is his foremost ideal is for the maintenance of quality nhe practice of the profession. The continuance of pfessional standards from one generation of doctors che next is his goal. He is well-loved by his students. Mdical students, particularly Brown students, he says, ar "super". They are dedicated beyond the realization most of society.

tin Felder, MD*

oday's students, Dr. Felder predicts, will practice er circumstances different from those existing now. every systems are changing. Therefore, the most portant continuities are qualities and standards at heart of medical care in the **individual physician-ent relationship.**

r. Felder believes that societies and associations of sicians — state societies and specialty organiza-s alike — need to improve their peer review activ-e. They have an important contribution to make in this realm. The absolute bedrock of medical professionalism is quality assurance, and hospital committees and medical societies are the appropriate overseers. Second opinions in surgery, in Dr. Felder's view, would not be necessary if hospital committees and society mechanisms were functioning as well as they could be.

J. Robert Bowen, MD*

The Providence Surgical Society's President, **Dr. J. Robert Bowen,** member of the surgical staff of Rhode Island Hospital, is also Clinical Associate Professor of Surgery in the Brown University Program in Medicine. Dr. Bowen's interests and concerns parallel Dr. Felder's. The teaching component of his career is meaningful to him. It is important, he says, to remember that only about 70 per cent of the learning and experience which forms the basis of successful practice of medicine is, strictly speaking, "scientific", and the other 30 per cent "humanistic".

Dr. Bowen is fascinated with the ever new scientific advances in surgery and is striving as President of the Providence Surgical Society to maintain the organization's reputation for excellence of its local scientific meetings. (The next meeting is to be held December 2, 1980. See "Medical Meetings".) The doctor predicts that some of the most significant innovations in surgery will be in the field of transplantations, and he predicts also that there will be many ethical and political ramifications of the new techniques, which will require thoughtful solutions.

On the subject of advances and increasing specialization in surgery, Dr. Bowen suggests the improvement of incentives to specialist surgeons to locate so as to fill needs in suburban and rural regions. Community support of local hospitals is essential for this, and medical societies can provide the stimulus.

Drs. Bowen and Felder share a specialty, a professional idealism, and a wide concern with associated issues and problems, well representing Rhode Island surgeons. ■

Financial Update: Investment Style

Robert F. Hall and Robert E. Washburn

The Providence Group* investment approach for a client naturally depends upon his particular requirements. Clientele have differing investment goals. No two portfolios are the same. Reasons are that no two personalties and circumstances are the same. There is no typical client. Some clients, for example, have no stocks at all. Why? Because their temperament isn't suited to the market's volatility. One of our clients has as his objective achieving a rate of return on his portfolio above the rate of inflation. Another never wants to lose a penny of principal. Another wants to exceed the return on the Dow Jones Industrial Average by at least 20 per cent annually.

We have found that a financial program well adapted to one person may be ill adapted to another. We must analyze income requirements, age, health, tax status, assets owned, temperament and other factors that may influence investment requirements.

Once a goal has been defined, the next question is — what kinds of securities should a client own? Some people have the notion that to be successful in investing they must have a magic formula for selecting securities that rise in price. In fact, however, there is no magic formula.

The investment philosophy we recommend for th individual who does not require income, who is in high tax bracket, and whose most important concern i inflation is as follows. Such an individual is seekin above average principal growth. With the maximu capital gains tax now at 28 per cent — and with inflatio continuing to average in excess of 11 per cent — w feel the most effective investment approach is to us equities of small to medium size growth companie Our research efforts have been directed to the study small to medium sized companies with outstandi histories of growth. We term these companies "emer ing growth companies" — companies whose grow rates for the last several years have been at least two three times the rate of the average corporation.

For the individual seeking above average princip growth, we would use selected growth companies wi the following major characteristics: (1) occupy a don nant position in an emerging industry; (2) above avera returns in equity and a strong balance sheet; (3) rap sales growth rates and above average profit margin and (4) ability to finance continued growth.

The companies that we would select for investme are those with established management. Because t companies are small by usual standards, the ability f management to implement good control is crucial. V would expect the companies to continue to provide th individual the potential for large capital appreciation a result of both earnings increases and multiple expa sion. Also, we would anticipate dividend growth excess of inflation.

("Financial Update" will be a recurring feature in t *Newsletter.)*

*The Providence Group — Investment Advisory Company — private investment counselling firm in Providence — clientele primarily individuals and charitable or non-taxable organizations — specializes in investment portfolio management — investment advisors for Rhode Island Medical Society.

To Be Or Not To Be — A Member

Charles E. Millard, MD*

"It is the punishment of wise men who do not participate in the affairs of government to live under the government of unwise men." (Plato)

With the ever growing interference of government in our daily lives, the application of the above quotation to the field of medicine is becoming increasingly evident.

Organized medicine in the United States has been responsible for the excellence of medical education and training of our profession. No amount of rhetoric by the opponents of American medicine can deny this fact. The excellence of our medical profession is the envy of the world. The best interest of our patients are served by a profession with such a standard. We must not allow the prerogatives of our organizations which protect this standard to be usurped.

Gunnar Biorck, MD, Professor of Medicine, Karolinska Institute, Stockholm and First Physician to His Majesty King Adolf VI offered the following observation: "I sincerely believe that the achievements of American medical science over the years have be and still are, outstanding in the world. The impress number of American Nobel prize winners in the t medical sciences should convince yourself of how world outside of the United States recognizes y achievements. *The American medical schools I know have produced the finest physicians in the world, b as regards knowledge and professional ethics.* Y should be very careful not to sacrifice these virtues and the support of them — in a well-meaning foolish attempt to conform to new ideas."

It is estimated that one third of the doctors in United States do not belong to any form of organi medicine. Their failure to realize what is occurring the political front must account for their apathy. T do not participate in politics because they main that their interest is in their patient's welfare. They test that they do not have time for both. This is a s defeating position. They and their patients are be overwhelmed by government controls. The erosion both of their basic rights is gradually taking place ur the guise of well-intentioned, but ill-advised, planne

Doctors have been heard to say, "I'm interested in my profession. I'm not interested in politics." W subjects such as appropriateness review or the SH plan are mentioned in the presence of these physici

(Continued next

dministrative Reports . . . Meetings with Officers and Staff

ednesday, September 10, 1980 . . . guests the meeting were Dr. H. Denman Scott* and Francine bbins, Director of Long-Term Care, Professional andards Review Organization . . . discussed with ests statistical approaches to evaluation of nursing me shortage problem in Rhode Island . . . followed by ular business: heard Kent County Medical Society sition on an application for an underserved designan by the Conimicut Health Center . . . announcement upcoming meetings to generate input to appropriatess reviews of inpatient obstetrics and pediatrics vices . . . Dr. Mathieu* presented suggested names response to AMA call for nominations to the follow- Councils: Judicial, Legislation, Long-Range Plang and Development, Medical Education . . . Dr. ninio Cardi* presented ideas for the improvement of ode Island Medical Society public relations pro- ms . . . reviewed miscellaneous correspondence.

ednesday, September 17, 1980 . . . Dr. lard* presented research findings on several dispancies between the recommendations of the ode Island State Health Plan and self-evident needs hin the state's medical delivery system (recomnded for publication) . . . Dr. Metcalf* presented imates received from SEARCH for statistical ses in support of regional health planning (for posle acceptance by the state Regional Health Planning mmittees) . . . discussed and proposed solutions to a sician (psychiatry) shortage problem in Bristol ntified by Dr. Ronald J. Cavanagh,* Medical Director, stol County Mental Health Center, Inc. . . . announcent that Drs. Mathieu (President),* Millard (President-ct),* Cunningham (AMA Delegate),* and Hager (AMA Alternate Delegate),* will attend the interim meeting of the AMA House of Delegates in San Francisco, December 7-10, 1980 . . . reviewed miscellaneous correspondence.

Wednesday, September 24, 1980 . . . guests of the meeting were Dr. Dario Herrera* and Dr. Peter DeBlasio . . . Dr. Herrera presented a brief update on preliminary arrangements for a series of Conferences on Basic Aspects of Running . . . the major portion of the meeting was devoted to a slide and narrative presentation by Dr. DeBlasio on theoretical and clinical aspects of acupuncture therapy . . . Dr. Hill* made pertinent suggestions for assurance of proper medical control and safeguards in the performance of this procedure . . . announcement of the nomination of Dr. David Carter as RIMS representative to the Board of the Association of Home Health Agencies of Rhode Island.

Wednesday, October 1, 1980 . . . guests of the meeting were Robert F. Hall, President, and Robert E. Washburn, Executive Vice President of The Providence Group, Inc., investment brokers . . . Hall and Washburn reviewed the status of RIMS investment funds . . . discussed RIMS relationship with Rhode Island Professional Standards Review Organization . . . charged Dr. Millard* to appoint an ad hoc subcommittee to the Committee on Delivery of Medical Care for the specific purpose of evaluating open versus closed hospital privileges issues . . . Dr. Mathieu* instructed staff to insure that Rhode Island Medical Society services are maintained during the official office hours 8:30-5:00 . . . reviewed miscellaneous business correspondence.

Be Or Not To Be — A Member *(continued)*

y admit that they have no idea of what they signify. er an attempt at explaining such things to them, they ally throw up their hands in despair and say there is hing that can be done about such things. However, misconception in this attitude is readily evident if cites the results of the recent cooperative effort of Rhode Island Medical Society, Rhode Island Hospi- Association, Rhode Island Osteopathic Association, Staff Physicians Association of Rhode Island ARI) in opposing parts of the State Health Plan. en the public was informed as to the dangers odied in this Plan, they reacted immediately. Their es and objections were clearly heard by all the ticians.

hanges are evolving in our health care system, and will continue. It is our responsibility to monitor fully these changes which are being proposed in a ildering and often confusing manner. We must be active vocal force dedicated to point out what we eve are pitfalls, and to praise where we see improvents.

you are not part of the solution, then you are part of problem. Obviously, the one third of our fellow sicians who do not belong to any form of organized dicine must be recruited. Then we can all work together to achieve our ultimate aim — the best medical care system possible. This goal cannot be achieved by dropping out of medical societies, but by being active members of these organizations. Your medical society is responsible for the finest medical care system ever developed, is the envy of the world medical profession. Let us try to maintain this position by closing ranks and becoming a force which must be reckoned with in any future proposed changes. Join and be active in the Rhode Island Medical Society and the American Medical Association. Be part of the solution and not part of the problem. ■

RIMS Interim Meeting

Town and Gown:
The Role of the Physician in the Health Care System in the 80s

Guest Speaker and Panel

December 3, 1980 — 1:00 pm

Fun at the Medical Follies

Richard W. Perry, MD*
Chairman, RIMPAC

A large and enthusiastic audience enjoyed the first annual "Medical Follies" on Saturday, September 13, 1980 at Faunce House Theater at Brown University, sponsored by the Rhode Island Medical Political Action Committee (RIMPAC).

The program was opened by Mark Miller of the Washington office of the American Policital Action Committee (AMPAC), who led the audience in the Pledge of Allegiance. This was followed by the singing of the Star Spangled Banner led by Mrs. Gloria Rossenbaum, accompanied by the orchestra. Members of the orchestra were Alastair Brown, Cornelius Arnow, and Joseph Arnow.

The entertainment started with a magic show by Dr. Robert S.L. Kinder* with assistance from some of the young members of the audience and cast. It was followed by a talk by Dr. Robert H. Rosen on "Socialized Medicine" with a movie in the background for added effect.

After intermission the audience was treated to a disco roller skate number by Tracy Cove. A guitar medley with songs by Alastair Brown followed and then a violin solo by Joseph Arnow. Musical selections by Dr. and Mrs. Anthony Duva, closing the program, we greatly appreciated. In fact, the audience did not wa Dr. Duva to leave the stage because his act was so w received.

The success of this first-of-a-kind affair is attrib able to the organizational efforts and enthusiasm of Robert H. Rosen. Last accounting indicated that alm $1000.00 was raised for RIMPAC by this success event.

Washington District Meets

The quarterly meeting of the Washington County Me cal Society was held on Wednesday, October 8, 19 Dr. Joseph J. O'Neill, President of the Washing County Medical Society, introduced Dr. David J. Kas psychiatrist, and Director of the Washington Cou Mental Health Clinic. Dr. Kass presented a mo which was followed by lively discussion. Followin delicious lunch, Dr. Peter L. Mathieu, Jr., Presiden the Rhode Island Medical Society, accompanied Howard Lawton, staff member, addressed the meet and elicited much interest in the affairs of the st society, especially in its relationship to the Washing County Medical Society. Membership is the key — district, RIMS, and AMA levels — if we hope to face 1980's with strength for survival. *"We need to ag gate into a cohesive, pro-active force,"* was Mathieu's principal plea.

Medical Meetings

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November

5 RI Society of Internal Medicine (RISIM-ACP); dinner meeting; Rhode Island Inn, Warwick; cocktails 6:00 dinner 7:00 pm (Speaker: Richard Egdahl, MD on "HMOs and IPAs Today")
6 Pawtucket Medical Society; special meeting; guest speaker: Leonard Dekoff, Esq.; Checker Club; 6:30 pm
11 RI Society of Allergy; fall meeting; University Club; 6:30 pm
12 Providence Medical Association; regular meeting; Roger Williams General Hospital Dining Room
13 RI Dermatological Society; regular meeting; Rhode Island Hospital
19 RIMS sponsored program, "Anxiety: A Clinical View"; RIMS Auditorium; 2:30 pm (Registration fee $15 includes buffet supper following the presentation)
25 RIPSRO Annual Meeting; RIMS Auditorium; evening

December

1 Rhode Island Medical Society Council; regular meeting; 6:00 pm
2 SPARI Annual Meeting; dinner meeting; Cranston General Hospital (David Hallmann, MD* will host A speaker on hospital relations)
2 Providence Surgical Society; regular meeting; Squantum Club
3 RIMS Interim Meeting (David Hallmann, MD,* Chairman will host AMA speaker on hospital relations)
5 Organization of State Medical Association Presidents (OSMAP); regular meeting; San Francisco
7-10 AMA House of Delegates, Interim Meeting; San Francisco
10 New England Pediatric Society; regular meeting
10 The Ted Chmura Symposium on Cancer; RIDH Auditorium; co-sponsored by RIMS; 1:00-4:15 pm
12 Pawtucket Medical Society; Christmas Party; Agawam Hunt
15 Blue Shield Board; regular meeting; 6:00 pm
16 RIMS Christmas Party; 6:00 pm; (presentation of district society charters and past presidents gallery show g

January

20 RI Society of Pathologists; quarterly scientific meeting; Women and Infants Hospital; 8:30 pm
21 RIMS House of Delegates; regular meeting; RIMS Auditorium; 2:00 pm

PRESIDENT'S CORNER

Insurance: They All Look Alike. Are They?

The subject of insurance is a complex one. There are basically two types of insurance. One, life insurance, is a big business and the basis for large cash reserves. The success of life insurance is a reflection of man's inability to save resources for possible catastrophe. Having life insurance is a man's bet that he will not live a normal life expectancy.

The second type of insurance, a type not always lucrative for insurance companies, is liability insurance. Malpractice insurance is a type of liability insurance. During the recession of 1973-1974 insurance companies, becoming alarmed by dwindling invested reserves, began to reduce commitments or withdraw from this liability insurance market. This produced the so-called malpractice insurance crisis that received much attention in the press.

Insurance is big business. To remain viable, it must constantly update its product. You may find that one of the traditional features, "the disappearing deductible", has itself disappeared. It may have been changed to a flat hundred dollar deductible. There may or may not be a deductible in your standard homeowner's policy, in claims for additional living expenses, "for renting temporary quarters when your home is made uninhabitable", for medical payments and for liability compensation to persons injured by your negligence.

In another change insurance companies have introduced the variable annuity which allocates part of your premium into a fixed dollar retirement income plan, and part into a variable securities account, with service charges up to 9 per cent of the annual premium for the first twelve years. Insurance companies usually pay their agents at least 55 per cent of the first year's premium as a commission on a whole life policy (plus 5 per cent a year for the next 9 years).

Changes also are occurring in the auto insurance industry. Certain auto insurance innovations, such as the "no fault" plan, require state legislative action. Under the "no fault" plan the insuree collects medical expenses and lost wages directly from his own insurance company regardless of blame for the accident, without suit on either part, except for expenses in excess of payments or costs not covered by the "no fault" policy.

Peter L. Mathieu, Jr., MD

State insurance authorities are cracking down on hard sell insurance mail order ads. You know the kind: "Fifty thousand dollars in cash, tax free when you're hospitalized. Enroll now before the deadline to get these special rates. . . ."

How can you tell whether one insurance policy costs more or less than another with the same face amount? Methods of comparing cost which do not take interest and other factors into account are open to criticism. Presently the interest adjusted cost index offers the most reliable guide. Companies are required to provide index figures upon request. Since the insurance industry is state regulated and not federally regulated, each individual state, through its state regulatory agency, is charged by law to maintain order in the insurance industry. Thomas J. Calderone, Jr., Esq, serves this function in Rhode Island as the Director of the state's Department of Business Regulation.

Any seasoned observer of insurance trends and problems will tell you that by all odds the continued explosion since 1974 of medical malpractice events and claims presents one of the most serious problems ever to face private enterprise. This is clearly apparent to those of you who take the time to study the report of the All-Industry Medical Mal-

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practice Insurance Committee, wherein the problems of providing multiple lines of insurance are clearly and effectively set forth. In our attempts to get a handle on the insurance industry, both as a private citizen and as your President, this administration has studied insurance and will offer suggestions to bring some semblance of order to what has become well-nigh chaos. In our continuing series we shall touch on several types of insurance, neglecting others that may be even more important and should require more attention. This first article will cover malpractice or casualty insurance. It will be followed next month by a report on health insurance policies, the criteria for choosing one over another, and why it's hard to pick a really good one.

Our discussion of medical malpractice insurance calls for a review of the history of the Rhode Island Joint Underwriting Association (JUA), created by legislation effective June 16, 1975. As stated in the regulations governing the JUA, the Director of Business Regulation found that (1) there existed (1974) a lack of a competitive stable market for medical malpractice insurance in Rhode Island; (2) as a result physicians and surgeons intended to withhold all but emergency services commencing July 1, 1975; (3) there resulted potential endangerment to the continued financial integrity and existence of hospitals and other health care delivery institutions in Rhode Island; (5) there was an imminent peril to the public health, safety and welfare of the people in Rhode Island; (6) there was an immediate need to provide a stable facility for medical malpractice insurance prior to July 1, 1975; therefore, "in accordance with Title 42, Chapter 35, Section 3, in the *General Laws of Rhode Island,* there is hereby promulgated and adopted the following emergency regulation which shall be known as a medical malpractice joint underwriting association in Rhode Island".

The basic purpose of this regulation was to provide a *temporary* market to make the necessary medical malpractice insurance available for a period not to exceed two years. The regulation was to alleviate the malpractice insurance crisis at that time, by providing that all casualty insurance companies in Rhode Island (now 301) be members of the JUA. The JUA created a stabilization reserve fund administered by three directors: one, the director of business regulation or his deputy; also, two directors appointed by the Director of Business Regulation (one a representative of the association, the other a representative of its policy holders).

The JUA is governed by a board of 11 directors, elected annually. Eight directors are elected by cumulative voting by the members of the association, with votes weighted according to members' net direct premiums written during the preceding calendar year. Three directors are appointed by the Director of Business Regulation as representatives of the medical profession. Representatives of eight member companies also serve on the board, elected at the organizational meeting of the members.

This administration has examined roles in the malpractice crisis situation of lawmakers, regulators, health administrators, physicians, and finally (and probably most importantly) the consumer of health services.

Basically, three professional groups are involved in malpractice: doctors, lawyers, and insurance companies. While most physicians never have a malpractice claim against them, state studies show clearly that a small group of doctors is responsible for the majority of claims. Pertinently, the medical system plays a part in the incidence of malpractice suits. The physician most likely to be sued for malpractice has certain identifiable characteristics: located in a geographical area already overly supplied with practitioners in his specialty; board qualified in the specialty, but not board certified; lives in an urban area, and has not been practicing defensive medicine for some time in spite of high malpractice premiums.

Although he is a bad insurance risk, this physician pays a premium no higher than that of any physician practicing the same specialty in the same geographic area. The cost of increasing malpractice claims in his specialty, some of which are the result of his incompetence, is paid equally by increased premiums to *all* doctors practicing his specialty. This hypothetical physician may have used drugs, or alcohol, or both. He may be mentally incompetent, or have been convicted of Medicare fraud. Despite all these characteristics of incompetence, this individual is not quickly identified by his medical associates. The Rhode Island Board of Medical Review, Mediation and Peer Review Committees of the Rhode Island Medical Society, and quality assurance committees in hospitals where he operates either respond very slowly or else fail altogether to identify such persons. Dr. Stephen J. Hoye, Chairman of the Rhode Island Board of Medical Review, is now working hard to correct the situation.

This administration recognizes that the identified malpractice prototype constitutes a hazard to his patients and to himself, and that he is also a hazard to the hospital where he practices his specialty. Since the 1968 Dowling versus Charleston Community Hospital decision, and the 1973 Gonzales

versus Nork decision, the courts are tending to lay responsibility at the hospital door.

This administration believes that the issues of medical staff membership, control, and restrictions demand resolution before the push to expand hospital corporate responsibilities into medical care can be viewed in proper perspective. Anti-trust considerations may stimulate this process. As essentially public institutions with limited capital resources, hospitals' participation in discussions and actions that result in malpractice accusations has usually been very limited. In most instances they should not be joined as defendants. One solution lies in limiting the hospital liability by law to a maximum of $100,000.

Indiana's Malpractice Act, often praised as a model for state laws protecting physicians from frivolous suits, has withstood a challenge to its constitutionality. The Indiana Supreme Court has unanimously upheld the Act, which provides for a state administered malpractice fund, with awards limited to $500,000 and liability of qualified physicians limited to $100,000.

This administration looks favorably on the Staff Physicians Association of Rhode Island (SPARI), formed in 1974 by the pattern of an AMA model for establishing medical society-hospital staff relationships. SPARI, which represents sixteen hospital medical staffs in Rhode Island working in liaison with the Rhode Island Medical Society, must increase its role in the hospital arenas, and serve up front in this complex triadic consortium as the physicians' representative. I believe that medical staffs should have an attorney other than the one representing their hospital. Situations in which separate counsel might be important include: (1) when an adversary relationship exists between a hospital administrator and a medical staff member; (2) when a critical issue demands a wide range of independent legal input; (3) when medical staff members are not satisfied with the capabilities of the hospital's attorneys. The medical staff of each hospital should identify a qualified local attorney for consultation or special representation should the need arise. This attorney, preferably experienced in health issues, should pay as much attention to problem solving as to advocacy.

Hospitals may face "corporate liability". Under the expanded theory of liability law that is gaining momentum in the courts, hospitals are increasingly being held responsible for acts of their staff physicians. The doctrine of "corporate negligence" makes it easier for an injured patient to file suit for malpractice against the hospital in addition to the physician. Thus, hospitals, exaggerating the implications of the doctrine in an overreaching effort to gain control of medical staffs, are claiming that their vulnerability requires them to supervise physicians and to exercise more authority in restricting staff privileges. The walls of Jericho are tumbling. Hospitals can no longer avoid liability on the basis that the health care provider is not an employee of the hospital. Yet, *no* grounds exist (not even the Darling case, because it is an impure case) for a hospital's governing board to be allowed to control a medical staff. Despite what proponents of corporate liability would like us to believe, the legal relationship between a hospital governing board and medical staff has not been clarified by case law or statutes in any jurisdiction.

I recommend modification or limitation of attorneys' contingency fees for malpractice cases. Compensating attorneys for malpractice work by contingency fees without consideration of time and expense of plaintiff's counsel is not in the public interest. The cost to attorneys of supporting plaintiffs and their families before and during trial should be identified. Moreover, contingency fees may be unethical and immoral since they permit attorneys to take from 25 per cent to 50 per cent of awards to patients.

Some recent court cases have possibly impacted on the incidence of malpractice verdicts against the physician by: (1) eroding the "locality rule" that only requires a physician to practice the quality of medicine generally maintained in his geographical area; (2) requiring that physicians practice medicine in the light of current medical advances; (3) introducing the *res ipsa loquitur* doctrine in very specific cases when an expert witness is not required; and (4) requiring informed consent.

Malpractice legal proceedings should never be tried before a jury. Courtroom histrionics make it difficult if not impossible for a member of the jury to analyze appropriately disputed facts, and to project in his mind the dollars needed by a patient. Past experience clearly indicates that jury awards bear a low relationship to the cost of the best future care for the patient. I ask the Governor to create "specialty courts" to deal with medical liability cases. I ask the Governor and the General Assembly to create laws to provide prompt arbitration which will both avoid delay to the patient with a just claim, and avoid the high costs of court trials. The present system has led to delays of more than five years, with yet no evidence of early resolution. *(To be continued)*

NOTES FROM THE PROGRAM IN MEDICINE

Cable Television

Cable television often is felt to be synonymous with entertainment. Indeed the idea of watching a movie or a football game in one's living room is what attracts most subscribers. A few sophisticated investors regard cable television as a growth industry. Its potential in health education, for professionals as well as for the general public, is a rather novel concept. The use of cable television for communications and transfer of data, from electronic mail delivery to the sharing of library and computer resources, is still at the experimental stage, but considerations of convenience and cost are likely to accelerate such applications.

These are the reasons why the medical community cannot remain indifferent to the debate concerning public service aspects of cable television.

On behalf of Brown University and its affiliated hospitals, it was my role, earlier this summer, to bring to the attention of the Public Utilities Commission some views on the cable television system proposed for Rhode Island, and its potential impact on the services rendered to the community by our network of institutions.

In short, we support the concept that the state cable television network should provide some element of public access *and* an institutional cable system for use by educational and health care groups. The institutional cable system should provide two-way interaction between participating agencies, and allow for programs to be transmitted to individual subscribers. If the cables, linkages and interconnects are laid at the same time as the primary distribution system, then the cost will be minimal, and the potential for flexible and cost-effective use in the educational sphere will be promptly established. We do not expect the cable television franchises to support all the operational costs of an educational network, but it is critically important that such a network be incorporated into the system from the onset, since proper cable layout could eliminate a major portion of the expenses associated with a staged development.

Potential applications of cable television are many:

Patient education: Since most of the hospitals already have internal television distribution systems that provide commercial and public television programs, these systems could easily and inexpensively be adapted to distribute health care programs originating on the institutional cable. This means that pre-packaged patient education shows could be sent from any central location or participating hospital to all patient rooms in another hospital. Through suitable interconnections with the standard subscriber cable, the same programs could be transmitted to the patient's home, a physician's office, or any health care facility.

Professional education: Television network linkages among the hospitals and the Brown University campus would allow for common scheduling of medical conferences and seminars, with the potential for two-way interaction from designated sites. A central repository of videotapes and disks could be tapped by students, physicians, nurses and other health care professionals for viewing at different locations, including their own homes. Eventually, satellite linkage would provide access to programs from the National Library of Medicine or health education networks anywhere in the country.

Public education: Because universities and hospitals would have a potential access into the homes of all subscribers, the educational network could produce programs for the general public, related for instance to preventive medicine, health maintenance or issues of general interest.

Institutional communication: Two-way interactions would not be limited to video conferences and educational programs. A daily updated, electronic bulletin board could announce seminars, grand rounds, and other programs much more effectively than posted notices or monthly bulletins, as well as summarize the outcome of educational or administrative conferences. Development of the video network could also lead to parallel development of a high speed, low cost data transmission network, which would allow the sharing of computer resources, data bases and bibliographic services.

Clinical applications: There are existing networks which link hospitals to outlying clinics by means of satellites, and which also allow telemetering of information from patients to consulting phy-

sicians over considerable distances. Such clinical applications are still experimental, but the future is certainly promising.

The potential of cable television for cost-sharing and cost-containment can benefit patients, physicians, institutions and third party payers. It behooves us all to be attentive to the public service value of a well-designed cable television network fo the State of Rhode Island.

Pierre M. Galletti, MD, PhD
Vice President (Biology & Medicine)
Acting Dean of Medicine

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EDITORIALS

Laboratory Testing in Teaching Hospitals

Published elsewhere in this issue of the *Journal* is the report of a conscientious effort by a senior medical resident in a local teaching hospital to reduce the incidence of unnecessary laboratory testing and to teach an important lesson to his resident staff.

These columns have long emphasized to our teaching colleagues the urgent necessity of incorporating such a philosophy in their teaching of students and the training of residents.

The author makes two cogent points: 1) that the big dollars can be saved by reducing the mindless repetition of relatively inexpensive tests, and 2) that much can be accomplished by a simple audit method, questioning the necessity of each test.

There is other evidence that the problem is being faced up to realistically both in our local Brown University Medical School (through course emphasis) and in the teaching hospitals (by the appointment of staff committees charged with this mission).

We commend the author and others who are at long last addressing this important problem in a constructive way.

Seebert J. Goldowsky, MD

Sports Medicine

With the return of students to the schools and colleges, the subject of sports medicine is a timely one. This discipline requires a special knowledge of the diagnosis, treatment, and prevention of sports related injuries, as well as an understanding of problems peculiar to athletes.

There is a great need for qualified orthopedic surgeons who will keep pace with the changes taking place in all sports. While their primary role is to treat injuries, a simplistic approach no longer suffices. The orthopedic surgeon who undertakes this task must have a working knowledge of exercise physiology, biomechanics, kinesiology, epidemiology, psychology, sociology, and other pertinent subjects. It is no longer enough to be able to treat injured knees, shoulders, and ankles, or to know how to condition or recondition an injured athlete. One must now have an understanding of the whole field of sports and be familiar with the demands placed on the musculoskeletal system of athletes by a range of sports. He must be knowledgeable not only in the management of the normal athlete, but in coping with the handicapped athlete as well. Athletic competition among the handicapped has been intense. They now have local, state, sectional, national, and international events, and even a world olympics.

The sports medicine physician must keep abreast of the subject by attending meetings of his colleagues and by reading the relevant literature. There are special publications, such as the *American Journal of Sports Medicine, Science in Sports, The Yearbook of Sports Medicine, The International Sports Science,* and others including orthopedic publications. There are even specialty journals on such subjects as biomechanics and kinesiology.

There is a President's Council on Physical Fitness, and 27 state councils on physical fitness, with 4 more in the making, bringing the total to 31. Only five orthopedic surgeons are participating in state councils; certainly more should become involved.

Education of others is another important responsibility of the sports medicine specialist. Trainers and equipment salesmen are among those needing further education. Nutritionists, masseurs, chiropractors, health-food fadists, even exercise Nautilus centers are candidates. Many of those attempting to

teach fitness have little knowledge of the physiology or pathology of the human system. The literature indicates that there are approximately 170,000 cultists. Not only must we deal with them, but we must communicate with politicians, civic leaders, labor leaders, sports lawyers, agents, and administrators as well, if we are to keep sports medicine on the highest level. To accomplish this a sports medicine information center would be a desirable resource.

At the school or college level, participation in sports involves many responsibilities. The athlete's responsibility is to keep in training, to play hard but fairly, to take the advice of his superiors, and to conduct himself in a gentlemanly manner so as to be a credit to himself, the sport, his school, his family, and his community.

It is the school's responsibility to assure that all prospective athletes undergo thorough pre-season medical examinations and receive proper pre-season conditioning and instruction in the sports in which they are involved. The coach and the school are to provide proper equipment and to make available properly constructed sites for competition.

Parents of athletes have the responsibility of encouraging the athlete to maintain the best possible condition and to inform the schools, coaches, or physicians of any physical impairments which may influence his participation in sports.

It is the physician's responsibility to provide the athlete with a competent pre-season medical examination, with emphasis on his past medical history and his fitness to participate safely in any given sport. This examination may reveal disorders not previously known to the athlete or his parents. The physician should also safeguard the athlete's health throughout the season, by attending all games and contact practice sessions, and by assuring that adequate emergency transportation of any injured player to a nearby hospital or clinic, preferably by ambulance, is available. It is also the responsibility of the physician to determine when an injured athlete may return to practice or to game competition. Under no circumstances should this decision be left to the judgement of coaches or trainers.

The principal purpose of conditioning is the prevention of injuries—by the development of the musculoskeletal system and stamina needed in any given sport, and by the building of resistance to fatigue. Conditioning should start preferably in early spring for fall sports. If a spring training session is not feasible, the athlete may be induced to conduct a major portion of the program by himself, guided by written instructions.

It is important to provide well-designed equipment. Such equipment makes for an effective program. If there are budget limitations, it is preferable to purchase a limited amount of good equipment rather than large amounts of second-rate equipment. However, the finest equipment is of no value unless the player is made to wear it. It is the responsibility of the physician, trainer, and coach to insist that the player wear the protective equipment and to insure that it fit properly. Well-fitting second-grade protective equipment is preferable to ill-fitting expensive protective equipment.

Intelligent coaching is important, since it not only fosters outstanding and skillful performances on the part of the athletes, but also lowers the incidence of athletic injuries. A good coach will act to prevent injuries, not only among his own players, but among his adversaries as well. A fair coach will discourage such unpleasant tactics as clipping, punching, elbowing, and spearing. A wise coach will plan his practice sessions for a time when the greatest number of his athletes can be present. An experienced coach will schedule practice sessions to take account of the weather of the day, including humidity, temperature, rainfall and other natural conditions.

The game officials also have an important role to play. Approved officials have generally participated in a rigid program of theoretical and practical instruction. Good officiating promotes enjoyment of the game by the spectators and the participants, but it also serves to protect the players from injuries. Officials have an obligation to interpret and enforce the rules governing the various sports. If officials are to perform well, coaches, trainers, and team members must also be familiar with the rules. The best official is one who is emotionally sound and well versed in the pertinent rules and regulations. An emotionally unstable or neurotic official is harmful to the game, and an unstable, easily excited one may even abet the incitement of riots.

Finally, as to facilities, adequate areas for play should be provided and properly maintained, whether they be grassy fields for football, polished floors for basketball, or smooth ice surfaces for hockey. All playing fields and areas should meet minimum standard requirements for size, proper maintenance of playing surfaces, and facilities for spectator control.

A teaching institution or training program can boast of having a sports medicine program, only if it meets these criteria.

A.A. Savastano, MD

RADIOGRAPHIC CASE OF THE MONTH

) inspiration

(b) expiration

listory:

wo year old child with sudden onset of dyspnea and tachypnea.

adiographic Findings:

rontal chest radiographs in inspiration (a) and expiration (b) show constant lucency of the left lung as ompared to the right. The left hemidiaphragm remains low and does not move.

or diagnosis and discussion turn to next page.

Diagnosis

Acute obstructive emphysema secondary to an aspirated peanut in the left main bronchus.

Discussion

Over 50 percent of aspirated foreign bodies in children occur in those under three years of age. The foreign body is usually a food particle, often a peanut. Timothy and barley grass are occasionally aspirated in young children and should be thought of in a child who coughs or wheezes in the summer months. In older children, an aspirated tooth may be discovered as an incidental finding on a chest film.

The radiographic changes of foreign body aspiration reflect the degree and location of bronchial obstruction and the time lapsed between the event and the examination. The most frequent early radiographic finding in children is obstructive emphysema, but atelectasis and infiltrate are also seen. The foreign body invariably lodges in a lower lobe bronchus, the right twice as frequently as the left. If it lodges in a bronchus so as to cause obstruction to the egress of air but does not impede the inflow of air, it then functions as a check valve thereby causing over-inflation of distal alveoli and obstructive emphysema. However, the lucent appearance of the involved lung in the chest radiograph may also be due to reflex oligemia from vasoconstriction, ie reflex decrease in perfusion secondary to decrease in ventilation. Obstructive atelectasis occurs when the foreign body completely blocks the bronchus to the inflow and egress of air. Air distal to the obstruction is absorbed resulting in loss of lung volume or obstructive atelectasis.

In adults the major cause of obstructive atelectasis is endobronchial obstruction secondary to carcinoma. The fact that atelectasis is not seen as commonly as emphysema may reflect air drift from adjacent normal lung parenchyma into the occluded segment. If the foreign body lodges in a smaller bronchus, the obstructive changes will correspond to that pulmonary segment. Organic material (especially those high in fatty acids such as peanuts) usually incite inflammatory changes within 24 to 48 hours with corresponding signs and symptoms of bronchial obstruction. With involvement of a smaller bronchus, the only sign may be persistent cough or wheezing and the only radiographic finding may be a small infiltrate usually in the lower lobes. The foreign body may remain asymptomatic indefinitely especially if it is inorganic and does not incite inflammatory changes or otherwise occlude the bronchus.

In this case, where aspiration is suspected and the inspiratory and expiratory films show evidence of air trapping, no further radiographic examination may be required. However, fluoroscopy will show diminished movement of the hemidiaphragm on the affected side and shift of the mediastinum toward the normal side on expiration. A perfusion lung scan may show decrease in perfusion on the affected side secondary to reflex vaso constriction.

Allan M. Deutsch, MD
Michael J. Ryvicker, MD
Howard Cohen, MD
Sanford Schatz, MD

References

Caffey J: Pediatric X-ray Diagnosis. Chicago, Year Book Medical Publishers, Inc, 1978, pp 377-390.
Fraser RG, Pare JA: Diagnosis of Diseases of the Chest. Philadelphia, WB Saunders Co, 1979, pp 1550-1553.

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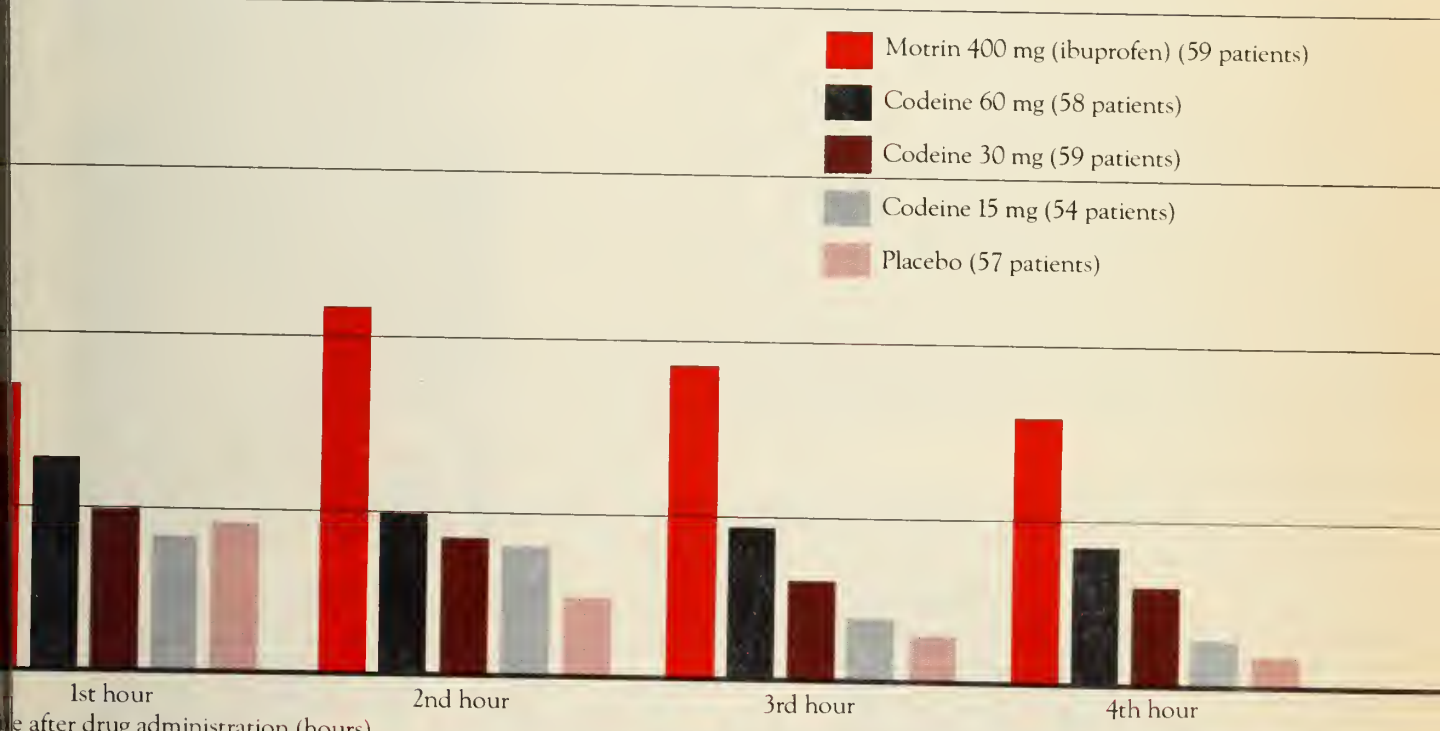

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Peptic ulceration and gastrointestinal bleeding, sometimes severe, have been reported. Ulceration, perforation, and bleeding may end fatally. An association has not been established. Motrin should be given under close supervision to patients with a history of upper gastrointestinal tract disease, only after consulting ADVERSE REACTIONS.

In patients with active peptic ulcer and active rheumatoid arthritis, nonulcerogenic drugs, such as gold, should be tried. If Motrin must be given, the patient should be under close supervision for signs of ulcer perforation or gastrointestinal bleeding.

Precautions: Blurred and/or diminished vision, scotomata, and/or changes in color vision have been reported. If these develop, discontinue Motrin and the patient should have an ophthalmologic examination, including central visual fields.

Fluid retention and edema have been associated with Motrin; use with caution in patients with a history of cardiac decompensation.

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*Incidence 3% to 9%.

Incidence less than 1 in 100

Gastrointestinal: Upper GI ulcer with bleeding and/or perforation, hemorrhage, melena. **Central Nervous System:** Depression, insomnia. **Dermatologic:** Vesiculobullous eruptions, urticaria, erythema multiforme. **Cardiovascular:** Congestive heart failure in patients with marginal cardiac function, elevated blood pressure. **Special Senses:** Amblyopia (see PRECAUTIONS). **Hematologic:** Leukopenia, decreased hemoglobin and hematocrit.

Causal relationship unknown

Gastrointestinal: Hepatitis, jaundice, abnormal liver function. **Central Nervous System:** Paresthesias, hallucinations, dream abnormalities. **Dermatologic:** Alopecia, Stevens-Johnson syndrome. **Special Senses:** Conjunctivitis, diplopia, optic neuritis. **Hematologic:** Hemolytic anemia, thrombocytopenia, granulocytopenia, bleeding episodes. **Allergic:** Fever, serum sickness, lupus erythematosus syndrome. **Endocrine:** Gynecomastia, hypoglycemia. **Cardiovascular:** Arrhythmias. **Renal:** Decreased creatinine clearance, polyuria, azotemia.

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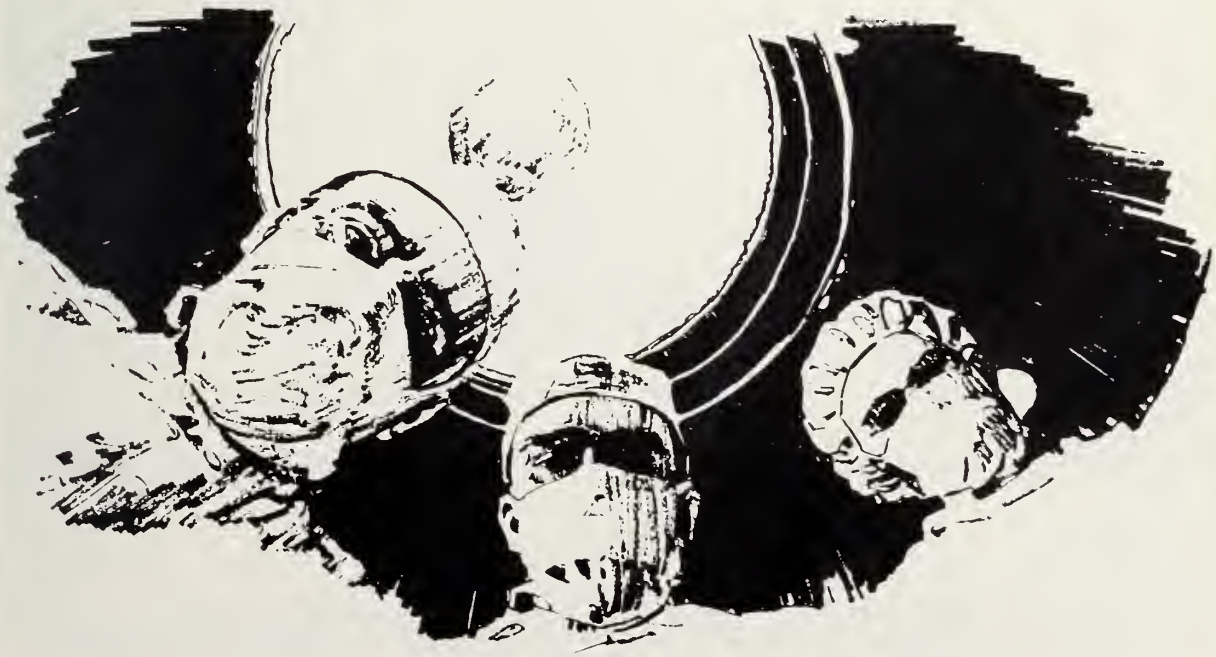

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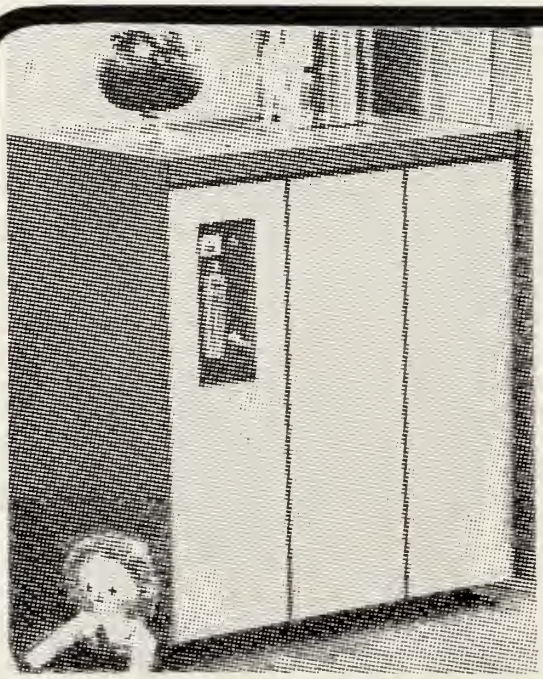

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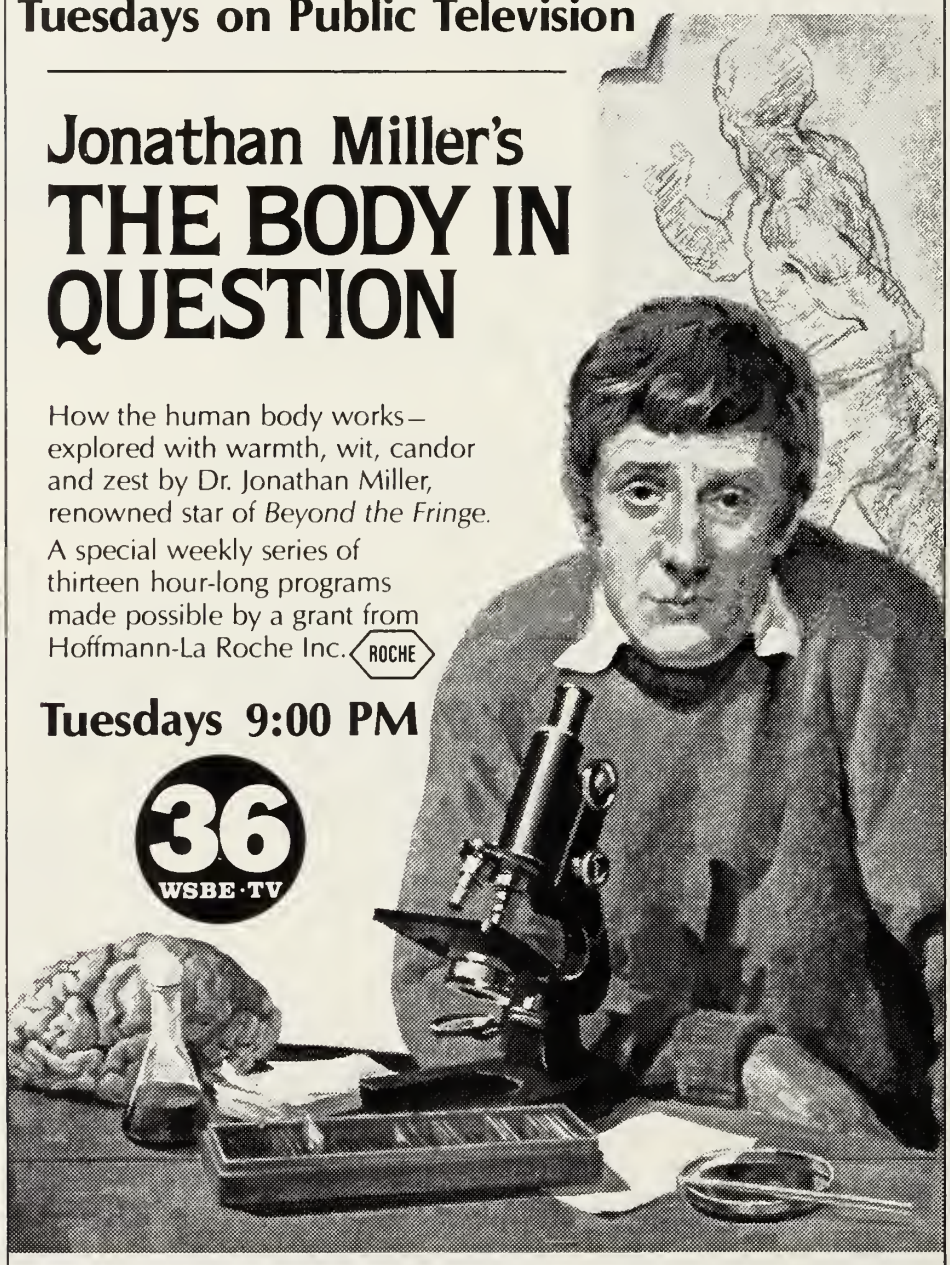

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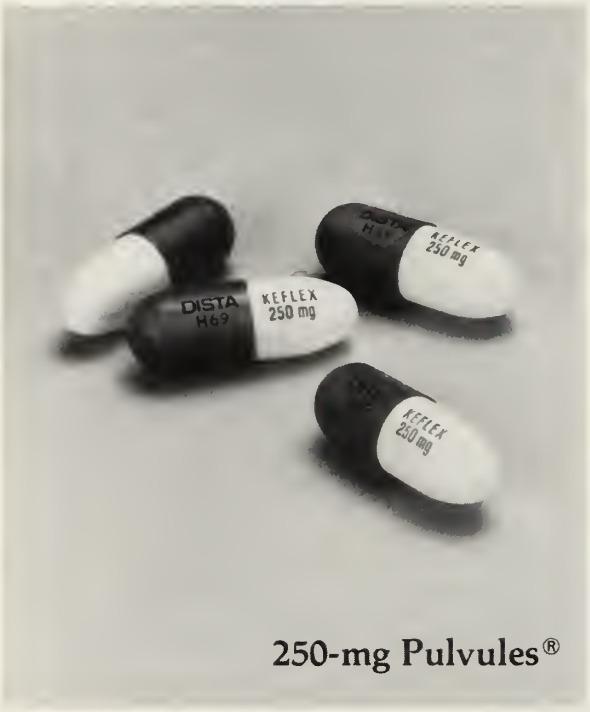

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Intracerebral Hemorrhage Associated with Total Parenteral Nutrition and Anticoagulation

Complication of Anticoagulation Is Reported in a Patient with CNS Disease Receiving TPN

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Since Dudrick *et al* first established the effectiveness of total parenteral nutrition (TPN), this mode of therapy has been used successfully in disease conditions characterized by catabolic states and malnutrition.[1] The sequelae of TPN are most commonly in the form of catheter-related mechanical problems and infectious and metabolic abnormalities[2] which may diversely involve the central and peripheral nervous system.[2-13] We here describe an additional central nervous system (CNS) complication and review the spectrum of nervous system involvement associated with TPN.

Case Report

A 38 year old male was admitted to hospital complaining of numbness, tingling, intermittent loss of fine motor coordination of his right hand, and difficulty in expressing his thoughts verbally, lasting approximately 6 hours.

Eight years previously he had had a left testicular resection for embryonal cell carcinoma, followed by chemotherapy and periaortic node radiation. Radiation enteritis developed, and in the following seven years he had multiple abdominal procedures for small bowel resection and lysis of adhesions. He became unable to maintain adequate nutrition. In July 1977, a central venous catheter for TPN was placed via the right jugular vein.

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In October 1977, he became febrile to 39.6°C. A right upper lobe infiltrate was revealed on chest x-ray study. Staphylococcus aureus grew from cultures of his blood and from a sacral abscess which developed during his hospital stay. He was treated with parenteral antibiotics for four weeks with a good clinical response.

In April 1978 after suffering myalgias, left shoulder and right hip pain, and temperatures to 38°C for three weeks, he was readmitted to hospital where 48 hours later he became febrile to 39.6°C. Blood cultures grew Staphylococcus aureus and beta hemolytic enterococcus. He was treated for four weeks with parenteral penicillin and gentamycin, again achieved a good clinical response, again returned home, and continued to use his TPN catheter. He felt well until the day of his admission 7/31/78 having spent the days prior to admission sailing with his family.

Physical examination on admission revealed an alert well developed, well nourished male in no

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acute distress. The blood pressure was 120/70 mm Hg, Temperature 37°C, pulse 76, respirations 12. Neck was supple without bruits. The catheter was palpable in the right jugular vein. Lungs were clear to percussion and auscultation. The heart was of regular rate and rhythm without murmurs, thrills, or gallops. Abdomen was soft with numerous scars and cutaneous fistulae present. Extremities were without cyanosis, clubbing, or edema. Neurologic examination including mental status, cranial nerves, deep tendon reflexes, motor and sensory testing, and cerebellar function was normal. Admission laboratory studies revealed a serum glucose of 80, BUN 21, sodium 140, potassium 4.5, chloride 101, CO_2 31, hemoglobin 13.4, hematocrit 41.7, white blood count 8,400 with 72 polymorphonuclear cells, 2 bandforms, 13 lymphocytes, 3 eosinophils, and 9 mononuclear cells. PTT 36/40. PTA 100 per cent activity. EKG was within normal limits. Chest x-ray film showed questionable infiltrate in the left lower lobe. Routine urinalysis was normal.

The lumbar puncture was traumatic yielding a bloddy first tube that cleared on successive tubes, and exhibited no xanthochromia. Cell count on the third tube was 732 RBCs and 10 lymphocytes. Glucose was 43, protein 45 with a normal opening pressure.

Hospital Course. Because of the possibility of pulmonary and cerebral emboli related to the intravenous catheter, it was decided to heparinize the patient. Accordingly, an intravenous bolus of 5,000 units of heparin was administered followed by continuous infusion. Five to ten minutes thereafter the patient's speech became slurred associated with an increase in numbness of the right hand. The heparin was stopped immediately, but over the next hour-and-a-half the patient progressed through a right hemiparesis and global aphasia to coma with decerebrate posturing. A repeat PTT one hour after heparinization was greater than 100 with a control of 37. On neurological examination the pupils were fixed and dilated, doll's eye maneuver showed no response, and there were no spontaneous respirations, a condition which necessitated intubation and respiratory assistance. During the next day he remained unchanged neurologically, and two electroencephalograms 24 hours apart were isoelectric. Blood cultures drawn on admission were reported as positive for gram-positive cocci, identified as beta hemolytic enterococcus sensitive to ampicillin, erythromycin, and chloramphenicol. On the second hospital day the patient experienced tachybradyarrhythmias followed by asystole and expired.

Table 1. Nervous System Complications Associated with Parenteral Nutrition

	References
Central Nervous System	
Wernicke-Korsakoff	8
coma	13
hepatic encephalopathy	2
embolism	
thrombotic (associated with endocarditis)	3,5
air	7
pseudotumor cerebri (internal jugular vein and transverse sinus thrombosis)	11
subarachnoid hemorrhage	5
intraventricular hemorrhage	5
intracerebral hemorrhage	*
abscess (mycotic)	3
aneurysm (mycotic)	3
meningitis	3
Peripheral Nervous System	
areflexic paralysis	6,12
phrenic nerve palsy	4
brachial plexus injury	10
Other	
cervical and supraclavicular pain with catheter migration	9
carotid artery laceration	10

(* present case)

Autopsy Findings

No evidence of recurrence of the embryonal cell carcinoma was found in any organ tissue. The lungs revealed bilateral acute bronchopneumonia with

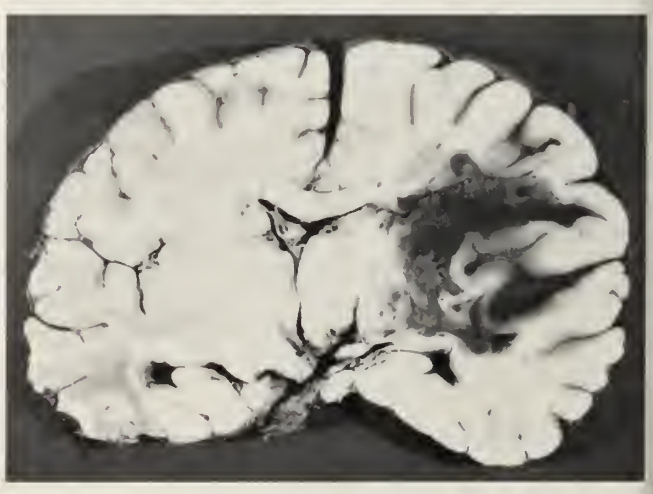

Figure 1. Subcortical hematoma of left frontoparietal white matter with associated subarachnoid hemorrhage.

abscess formation. Two vegetations each measuring 0.3 cm by 0.4 cm were found adherent to the auricular side of the mitral valve leaflets. No organisms were identified on gram stain of these lesions. No clots were found on the catheter tip located just outside the right atrium.

Neuropathological findings. The brain on gross examination showed diffuse subarachnoid hemorrhage, maximal over the left vertex. A large subcortical hematoma in the frontoparietal white matter dissected toward the left lateral ventricle (Fig 1). The basal ganglia were preserved. Focal petechial hemorrhages were seen in the central and temporal white matter of the right hemisphere. Left sub-falcial and tonsilar herniation and secondary brain stem hemorrhages were noted.

Microscopically the recent hematoma was partially demarcated by laminated fibrin and contained lysed red cells, foci of polymorphonuclear leukocytes and basophilic colonies of bacteria. Postmortem colonization was also noted in pial and parenchymal vessels in both hemispheres related or unrelated to petechial hemorrhage. Ischemic change was limited to left hippocampal neurons. Stasis thrombi with marginal white blood cells and perivascular extravasation were numerous in thalamic nuclei and brainstem. No aneurysm, anomalous vessels, or vascular emboli were detected.

Discussion

Long-term nutritional support has been achieved with TPN for periods of up to five years.[14] As an increasing number of patients are maintained on TPN, sequelae may be seen more frequently. This contention is supported by the number of neurologic complications reported during the past decade (Table 1).

Progressive neurologic deterioration from an intracerebral hemorrhage within minutes of heparinization accompanied by a markedly elevated partial thromboplastin time and multiple petechial hemorrhages in the brain strongly suggest an anticoagulation-related complication in this patient. Equally important, but less clear, is the CNS abnormality underlying the neurologic symptoms which preceded the hemorrhagic compli-

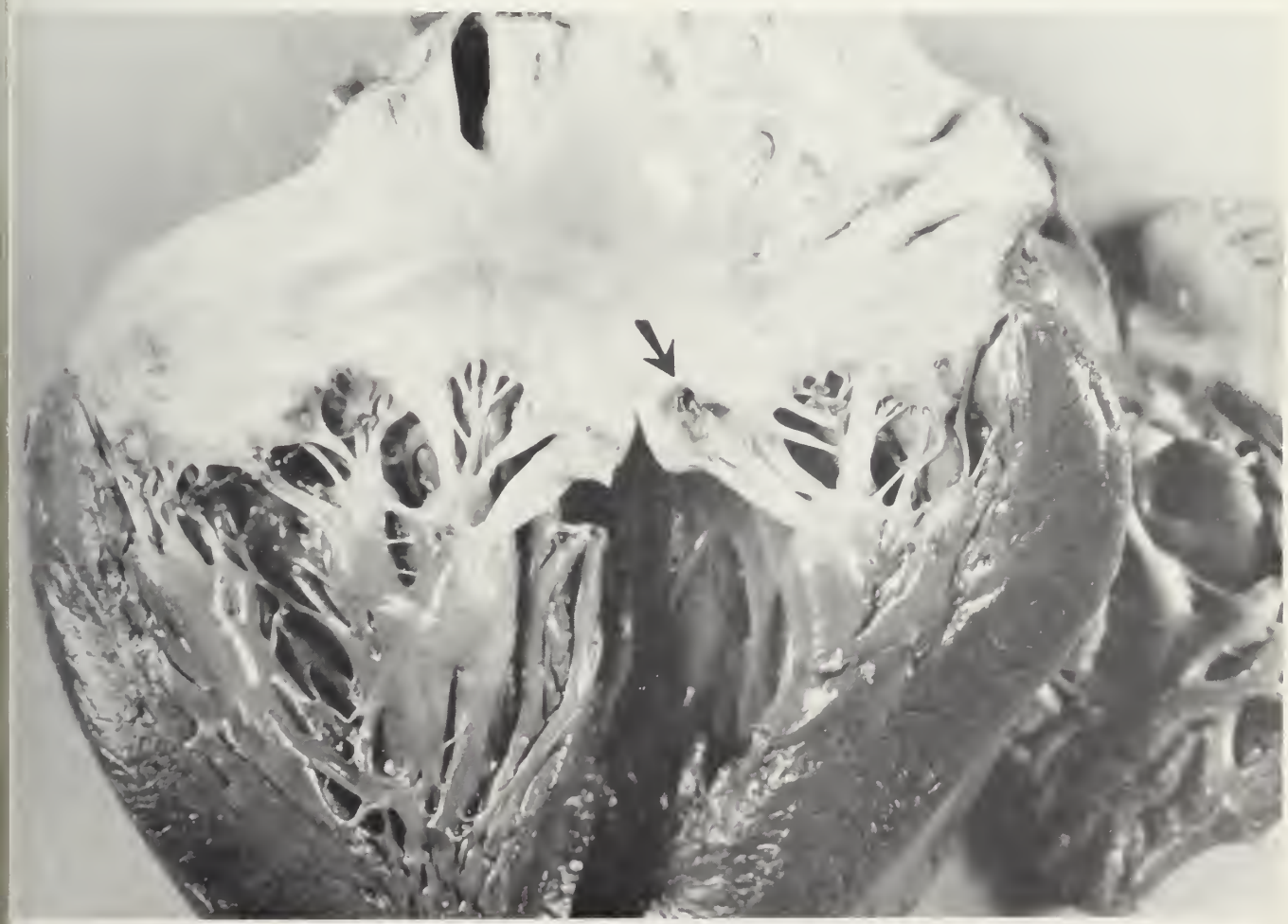

Figure 2. Friable vegetation on auricular surface of mitral valve (arrow).

cation. Septic cerebral infarction and cerebral embolus from aseptic mitral vegetations are two etiologic considerations. The presence of lung abscess, septicemia and multiple bacterial colonies in the brain favors the former; however, cerebral embolus from the cardiac vegetations with secondary bacterial invasion cannot be excluded. Cerebral embolus originating from the catheter is unlikely in the absence of a right-to-left shunt as well as the absence of clot formation on the distal end of the alimentation line.

Reports of neurologic complications secondary to an infectious process with TPN are limited. Edwards *et al*,[5] described three infants less than two months of age with septicemia secondary to TPN who developed bacterial endocarditis. Postmortem CNS findings included subarachnoid hemorrhage, intraventricular hemorrhage, and fibrin thrombi in the cerebral cortex. Although fungal and bacterial endocarditis have been reported with parenteral nutrition in adults,[3,15] associated CNS complications are rare.[3] Aseptic cardiac vegetations, as seen in our case, although occurring with intravenous devices,[15] have not previously accompanied TPN and may represent marantic or healed bacterial endocarditis (Fig 2).

Based on the findings of this case, blood culture results should be obtained prior to initiating anticoagulation therapy for focal cerebral signs in patients on TPN despite the clinical absence of sepsis. Antimicrobial therapy solely or in conjunction with anticoagulation may be the treatment of choice when blood cultures are positive. In addition, echocardiography should be performed on all such patients in an attempt to identify valvular pathology as a possible source of cerebral emboli.

Summary

Fatal intracerebral hemorrhage occurred in a patient on long-term total parenteral nutrition within minutes after heparinization for suspected cerebral embolus. Unrecognized subclinical septicemia and mitral valve vegetations found at autopsy were features which may have predisposed to the hemorrhagic complication.

In addition to a high degree of suspicion of sepsis in such compromised individuals, echocardiography to identify mitral valve lesions should be included in the evaluation of patients with CNS involvement associated with TPN.

References

1. Dudrick SJ, Wilmore DW, Vars HM, et al: Long term total parenteral nutrition with growth, development, and positive nitrogen balance. Surgery 64:134-141, Jul 68.
2. Fleming CR, McGill DB, Hoffman HN, 2nd, et al: Total parenteral nutrition. Mayo Clin Proc 51:187-199, Mar 76.
3. Case Record of the Massachusetts General Hospital (Case 27-1979). N Engl J Med 301:34-42, 5 Jul 79.
4. Drachler DH, Koepke GH, Weg JG: Phrenic nerve injury from subclavian vein catheterization. JAMA 236:2880-2881, 20 Dec 76.
5. Edwards K, Ingall D, Czapek E, et al: Bacterial endocarditis in 4 young infants. Is this complication on the increase? Clin Pediatr 16:607-609, Jul 77.
6. Furlan AJ, Hanson M, Cooperman FR, et al: Acute areflexic paralysis. Association with hyperalimentation and hypophosphatemia. Arch Neurol 32:706-707, Oct 75.
7. Green HL, Nemir P Jr: Air embolism as a complication during parenteral alimentation. Am J Surg 121:614-616, May 71
8. Kramer J, Goodwin JA: Wernicke's encephalopathy. Complication of intravenous hyperalimentation. JAMA 238:2176-2177, 14 Nov 77.
9. Mullen JL, Oleaga J, Ring EJ: Catheter migration during home hyperalimentation. JAMA 238:1946-1947, 31 Oct 77.
10. Ryan JA Jr, Abel RM, Abbott WM, et al: Catheter complications in total parenteral nutrition. A prospective study of 200 consecutive patients. N Engl J Med 290:757-761, 4 Apr 74.
11. Saxema VK, Heilpern RJ, Murphy SF: Pseudotumor cerebri. A complication of parenteral hyperalimentation. JAMA 235:2124, 10 May 76.
12. Weintraub MI: Hypophosphatemia mimicking acute Guillain-Barre-Strohl syndrome. A complication of parenteral hyperalimentation. JAMA 235:1040-1041, 8 Mar 76.
13. Wyrick WJ Jr, Rea WJ, McClelland RN: Rare complications with intravenous hyperosmotic alimentation. JAMA 211:1697-1698, 9 Mar 70.
14. Jeejeebhoy KN, Langer B, Tsallas G, et al: Total parenteral nutrition at home: Studies in patients surviving 4 months to 5 years. Gastroenterology 71:943-953, Dec 76.
15. Greene JF, Cummings KC: Septic endocarditis and parenteral feeding. JAMA 225:315, 16 Jul 73.

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Laboratory Testing in Teaching Hospitals: Impact on the Cost of Health Care

A Simple Audit Can Produce Results in Reducing Costs

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A major contributor to hospital costs today is the clinical laboratory. These costs are due primarily to a marked increase in the type and volume of tests performed in hospital laboratories over the past decade. The major culprit in the growth of medical expenditures is an increase in the volume of low-cost services such as laboratory tests and x-ray studies rather than a shift to the use of large, expensive technologies for diagnosis or treatment.[1]

A recent review of this subject notes that if the annual operating costs of the nation's four largest technologies (computerized tomography, scanning, electronic fetal monitoring, coronary artery bypass surgery, and renal dialysis) were reduced by half, the net savings to the nation would equal less than one per cent of last year's bill for health care.[2] Similarly, although approximately $600 million was spent nationally for large item capital equipment for hospitals in 1973, the bill for laboratory studies increased an estimated $1 billion that same year.[3] If increased laboratory costs are a major component of the escalating national health care bill, then one must ask if these additional tests are essential to good medical care. Are 30 laboratory tests per case allowing physicians to treat uncomplicated appendicitis more effectively than when five tests per case were ordered in 1951?

Several studies indicate that in teaching hospitals laboratory tests are ordered excessively.[4-7] Griner and Liptzin reported in 1971 that unnecessary follow-up testing, often after the initial results were normal, constituted the majority of this excess.[4] In addition, although there was a 27 per cent increase in the number of laboratory studies ordered in patients hospitalized with the diagnosis of diabetic ketoacidosis in a three year period, this did not affect the outcome of their care. Similarly, in a study by Dixon and Laszlo, in which house officers were limited in the number of laboratory tests they could order, it was possible to reduce the number of laboratory tests by 25 per cent without eliminating essential information.[5]

Many factors contribute to the excessive use of laboratory tests in teaching hospitals. Of these, the most important are: 1) the house officer's need to "work-up" a patient completely to satisfy his supervising resident or attending physician; 2) the application of test "routines" and "standing" orders (for example, ordering an SMA 12 every Monday and Friday) especially in intensive care areas; 3) the "shotgun" approach to test ordering (simultaneous ordering of secondary diagnostic tests in addition to primary, screening tests); and 4) diagnostic "overkill" (ordering two or more confirmatory tests when one will suffice).

To define the extent of excessive laboratory testing at this institution, an audit was performed. The charts of 90 patients on the medical service were reviewed, and the number of laboratory tests per patient per week was calculated. The house officer caring for each of these patients was asked how each of these tests was influencing his or her patient's management. A test which could not be justified was considered "unnecessary". The number of unnecessary tests performed per week was tabulated and the total costs of these tests was calculated (Table 1). The cost of unnecessary

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laboratory testing per week in November 1979 was approximately $4000. The most frequently ordered test was the SMA 6 (serum sodium, potassium, chloride, total CO2, BUN, and glucose).

Table 1. Comparison of Audits of Unnecessary Laboratory Testing Between November 1979 and January 1980.

"Unnecessary" Laboratory Test	# per week November 1979	# per week January 1980
1 CBS with Differential Count	31	0
2 SMA 6	62	23
3 SMA 12	55	0
4 Glucose	33	0
5 Prothrombin Time	16	0
6 Creatinine	0	10
7 Platelet Count	2	0
Total	199	33
Total cost per week	$4000.00	$980.00

Between November 1979 and January 1980, several strategies were employed to reduce this cost: 1) "Standing" laboratory orders were discouraged so that the house officer was required to review test results daily and then reorder tests as needed; 2) physicians at daily housestaff conferences were encouraged to include cost analyses in their discussions; and, 3) following case presentations at weekly staff conferences, analyses of the cost and volume of laboratory testing were presented and critically reviewed.

The results of the January audit, again reviewing the charts of 90 patients on the medical service, are presented in Table 1. Although the SMA 6 still was ordered the most frequently, the total number and cost of unnecessary laboratory tests were markedly reduced. Several independent variables may have contributed to this reduction (such as severity of illness, and length of hospitalization), but the interventions outlined above played some, if not a significant, role.

If future health care costs are to be curtailed, the use of the clinical laboratory in teaching hospitals must be reduced. This can be done safely, without jeopardizing patient care. Although the study at this institution was limited and long-term follow-up is not complete, it is clear that specific intervention can result in cost reduction. First, the extent of the problem must be identified, using a simple audit system. Second, policy changes and educational strategies must be identified such as: 1) the elimination of "standing" laboratory orders and test routines, 2) discussion of laboratory costs at daily conferences and grand rounds, 3) specific didactic sessions which review the specificity and sensitivity of laboratory tests and their application to patient care, 4) encouragement of teaching attending physicians and supervising residents to review the use of laboratory tests when discussing patient care on rounds, and 5) continuous monitoring of the effect of these strategies on the reduction of volume and cost of laboratory testing through repeated audits.

Creative program directors and house officers could develop similar or other strategies to achieve this goal. This will require time and sustained effort, but should contribute to reducing the cost of good medical care in the years ahead.

Summary

Laboratory testing in teaching hospitals is excessive and contributes significantly to the cost of national health care. Ninety clinical charts at this institution were reviewed in November 1979, and the number of laboratory tests ordered per week per patient was tabulated. House officers were asked to justify the use of each test. When they could not, the test was considered "unnecessary". Specific policy changes and educational strategies were instituted, and an audit in January 1980 revealed a marked reduction in the volume of excessive testing. Simple audits should be used in teaching hospitals to define the extent of excessive laboratory testing and repeated after educational and policy changes have been implemented. A reduction in the volume of low-cost technologies will have the greatest impact on the price of health care in the future.

References

1. Scitovsky AA, McCall N: Changes in the Costs of Treatment of Selected Illnesses, 1951-1964-1971. Publication No. [HRA] 77-3161. US Department of Health, Education and Welfare, 1976.
2. Moloney TW, Rogers DE: Medical technology — a different view of the contentious debate over costs. N Engl J Med 301:1413-1419, 27 Dec 79.
3. Fineberg HV: Clinical chemistries: the high cost of low-cost diagnostic tests, in Altman SH, Blendon R: Medical Technology: The Culprit Behind Health Care Costs? Publication No. [PHS] 79-3216. Department of Health, Education and Welfare, 1979, pp 144-165.
4. Griner PF, Liptzin B. Use of the laboratory in a teaching hospital: Implications for patient care, education and hospital costs. Ann Intern Med 75:157-163, Aug 71.
5. Dixon RH, Laszlo J: Utilization of clinical chemistry services by medical house staff. Arch Intern Med 134:1064-1067, Dec 74.
6. Griner PF. Use of laboratory tests in a teaching hospital: long-term trends: Reductions in use and relative cost. Ann Intern Med 90:243-248, Feb 79.
7. Eisenberg JM: An educational program to modify laboratory use by house staff. J Med Educ 52:578-581, Jul 77.

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1979 Fiske Fund Prize Essay

The Effects of Modern Therapeutics on the Human Gene Pool

Changes in the Gene Pool Will Likely Proceed at a Measured Pace

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The effects of modern therapeutics on the human gene pool was primarily of academic and didactic interest until 1967, when it was demonstrated that genetic disorders could be diagnosed and monitored by chromosomal and biochemical analysis of amniotic fluid and fetal cells. In rapid succession abortion was legalized, cytogeneticists were able to differentiate X from Y sperm, cloning was accomplished, and finally preimplantation ectogenesis was successfully accomplished by English physicians. Additionally, advances in genetic engineering with modification of gene complements of living organism by synthesis of recombinant DNA molecules and the introduction of these molecules into cells, pharmacogenetics, and the treatment of Rh negative babies by intraperitoneal transfusion have caused considerable alarm that these advances may have an adverse effect on the genetic pool. At the same time many ethical, moral, social, and philosophical questions have arisen.

Modern clinical genetics is a prerequisite to practice for all physicians as supported by the following facts:

It is now widely known that each of us "carries" two to six lethal genes and many more nonlethal, but deleterious hereditary factors. Furthermore, it has been estimated that (1) 12 million Americans suffer from disease or disability caused, in whole or in part, by genetic factors, and (2) that about 5 per cent of all babies born today have birth defects due to abnormal genes or chromosomes, maternal viral infections, or combinations of hereditary and environmental elements. More than 2,000 traits are catalogued which have been positively or tentatively shown to be determined by a single gene, and more than 100 new genetic defects are being added to the list each year.[1]

Almost half of the birth defects observed among more than 18,000 live births at the Boston Hospital for Women could not be attributed to a specific environmental or genetic defect. Multifactorial inheritance, in which both genetic and environmental influences cause the malformation, was the single most common finding, occurring in 0.6 per cent of all newborn infants. This is the basis for many malformations, such as heart defects and cleft palates. It is not known how many genes or which environmental factors are involved, but parents with one affected child have an increased risk of having another affected child.

Chromosome abnormalities occur with much greater frequency in spontaneous abortions and stillbirths than in live births; chromosome abnormalities occur in 60 per cent of all miscarriages but in only 0.6 per cent of newborns.

Environmental factors leading to congenital malformation are more difficult to discover, largely because of the difficulty of sorting out among the wide variety of environmental exposures each woman has experienced. Only 0.2 per cent of births

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had defects attributable to maternal drug ingestion, and only 0.8 per cent had defects caused by various maternal medical conditions such as diabetes.[2]

Factors Determining Size and Quality of Gene Pool and Resulting Problems

The size and quality of the gene pool is determined by the number of carriers, not by the number of those affected. This fact raises several problems in genetic research: 1. By eliminating those affected by such diseases as Tay-Sachs we are encouraging an increase in carriers. 2. By treating phenylketonurial (PKU) patients we are not only enlarging the number of carriers, but effectively creating a new disease. 3. Carriers of recessive genes may have some genetic advantage. 4. Are desirable, creative qualities carried in the same genotype with undesirable qualities considered undesirable?

Joanne Nadel posited these problems and discussed them as follows:

Tay-Sachs disease is a genetic disorder which is uniformly fatal, striking apparently normal healthy infants with gradual mental retardation and death by 3-5 years of age. If both parents are carriers, the disease can be detected in utero by amniocentesis. The couple can then, and usually does, elect to have an abortion, and then try again for a normal child. However, that normal child may be a genetic carrier of the disease. Thus the number of carriers in the general population may increase, because couples with a previous carrier status usually stopped having children after giving birth to one Tay-Sachs victim. What will be the effect on the pool?

Another significant problem in genetic research is to determine what happens to those affected with genetic disorders who live to adulthood through proper medical care. In the case of PKU, such treatment is not only enlarging the number of carriers in the genetic pool, but is also effectively creating a new disease. If detected in the first few weeks of life, the infant can be placed on a special diet until brain growth is complete. The diet will prevent the buildup of phenylalanine levels, so that the child can be expected to live a comparatively normal life and be able to adopt a normal diet in adulthood. The high phenylalanine level will not hurt a patient once development is complete.

However, if a PKU mother becomes pregnant, her child will be retarded, even though it may not actually have PKU. High phenylalanine levels in utero will cause retardation or microencephaly. The PKU mother who wishes to have normal children has the alternative of going back to a low phenylalanine diet and continuing it through pregnancy, so that her children will not become retarded. Those children, however, will be carriers.

Nadel, in her discussion of carriers of recessive traits, continued, "It should be remembered that the carrier of a single recessive gene may have some genetic advantage. Researchers now believe, for instance, that individuals in Africa who possessed the sickle cell trait might have been immune to certain types of malaria. Therefore they survived longer and passed the trait on, resulting in an increase in the gene's frequency among the black."

There is, too, the as yet incalculable question: Are desirable, creative qualities perhaps carried in the same genotype with the qualities normally considered undesirable? Many geniuses and great people of history are remembered as not being normal, stable, average persons. Many were psychotic, alcoholic, homosexual, or afflicted with some physical or psychic quirk which might be considered "heritable." Lord Byron, Tschaikovsky, daVinci — the list of great "abnormals" is endless. Toulouse-Lautrec suffered from a crippling bone defect passed on by his parents who were first cousins. Charles Steinmetz was nearly turned back at Ellis Island because of his hunchback. After the intercession of an influential friend, he was allowed to stay in America, where he put into volumes almost everything the civilized world knows about electrical current and its uses.[3]

What therapeutic and diagnostic modalities are available to the practicing physician? And how will these affect the modern gene pool?

Available Therapeutic Modalities

The quality of the human gene pool can be affected directly or indirectly by the following: amniocentesis and prenatal diagnosis, preimplantation ectogenesis, genetic counseling, selective abortion, intrauterine therapy, pharmacogenetics, radiation, artificial gene synthesis and recombinant DNA techniques, and finally environmental factors. We shall discuss these individually and collectively.

Indications for Amniocentesis and Possible Diagnoses

Amniocentesis has made possible the antenatal diagnosis of many genetically transmissable diseases. Analysis of the amniotic fluid for enzymatic activity and cell culture makes possible the diagnosis of several sex-linked diseases and more than 50 inborn errors of metabolism. The indications and diseases are listed in Tables 1 and 2.

Other Modalities in Prenatal Diagnosis

A. X-ray examination makes possible the discovery of some limb reduction anomalies.

B. Ultrasonography can detect gross malformations late in pregnancy. Anencephaly is one such condition in which this diagnostic modality is helpful.

C. Recently introduced fetoscopy makes possible the visualization of the fetus, but this is in use only at large centers. With the fetoscope it is now possible by obtaining a sample of fetal blood prenatally to diagnose sickle cell anemia, the second most common severe genetic disorder.

Amniocentesis and Therapy

In 1960 A.W. Liley popularized this procedure when he successfully performed an intrauterine transfusion on a fetus with severe erythroblastosis fetalis. Analysis of amniotic fluid is now the most reliable means of diagnosing and managing this disease. Since the fetal condition is monitored by the bilirubin concentration, amniocentesis and serial determination of bilirubin offer the only reliable method of fetal monitoring.

Another diagnostic and therapeutic test depends upon the relationship between the phospholipids lecithin and sphingomyelin and lung maturity. The ratio between the entities provides an index to fetal maturation which aids in the treatment of affected infants. The vitamin B_{12} responsive form of methylmalonic acidemia is an inborn error of metabolism that may be treated before birth. A patient, whose fetus was affected with this disorder, was detected at the 19th week, and was treated with massive doses of B_{12}. With labor induced at 41 weeks, a healthy child was delivered and developed normally.[4]

In some conditions therapy may be preventive. Antepartum or neonatal diagnosis is important in recessively inherited metabolic disorders. If the physician is cognizant of parents who have an increased risk of producing children with an hereditary disorder or who may themselves have such a disorder, he may forestall mental retardation or even death. Examples are the galactosemias, phenylketonuria, and salt-losing adrenogenital syndrome. In these disorders, a phenotypic element may be a forboding of neoplastic degeneration, eg, multiple endocrine adenomatosis, basal cell nevus syndrome, Gardner's syndrome, and multiple polyposis of the colon. The alertness of the physician in recognizing such offspring may prevent death from these malignant neoplasms.

Preimplantation Ectogenesis

The recently reported success of P.C. Steptoe in England in bringing an infant to term by this

Table 1. Indications for Amniocentesis

1. Maternal age over 35 years.
2. Determination of sex in X-linked disease where mother is known carrier, even though prenatal detection of the suspected disease is not possible.
3. Previous birth of a child with neural tube defect.
4. Sex-linked disorders where mother is known carrier and prenatal diagnosis is possible; ie, Fabry's disease, Hunter's syndrome and Leschke-Nyham syndrome.
5. Parent known carrier of recessive metabolic disorder and in which prenatal diagnosis is possible; ie, Tay-Sachs disease.
6. Antecedent birth of a child with chromosomal abnormality.
7. Parent with known translocation chromosome.
8. Birth of previous sibling with an inherited biochemical disorder capable of being diagnosed prenatally.

Table 2. Examples of Biochemical Diseases

a. Galactosemia.
b. Glycogen storage disease (Types II and IV)
c. Fabry's disease.
d. Gaucher's disease.
e. Adrenogenital syndrome.
f. Methylmalonic acidemia.
g. Hurler's syndrome.
h. Tay-Sachs disease.
i. Lesch-Nyham syndrome.
j. Generalized gangliosidosis.
k. Hunter's syndrome.
l. Niemann-Pick disease.
m. Maple syrup urine disease.
n. Juvenile GM 1 gangliosidosis.
o. Lysosomal acid phosphatase deficiency.
p. Morquio syndrome.
q. Krabbe's disease.
r. Beta-glucuronidase deficiency.
s. Metachromatic leukodystrophy.

method has raised much heated discussion. The possibilities for use of this procedure in human infertility due to congenital or inflammatory blockage of the fallopian tubes, or where ovaries are defective or absent, are limitless.

Ectogenetic procedures are envisioned as promising research means of studying chromosomal disjunction, the behavior of translocations during meiosis, and the mechanism of gene activation and inactivation, as well as spontaneous abortion and contraception.

There has been much objection to the procedure because fetuses cannot give informed consent. Risks to the fetuses are unknown, and it has caused objections from many church leaders as being unethical. There are objections because of the waste of human embryos, which they contend is tantamount to murder. Many are concerned that governments may use the procedure to control reproductive practices.

The effect of this procedure on the genetic pool potentially would appear to be relatively profound. A great deal of adjustment and disputation, philosophical and otherwise, however, will be necessary before its impact can be fully evaluated.[5]

Relaxed Selection

This issue was addressed by Crow. He stated that, where single genes are involved, the effects of selection can be predicted with accuracy, if the selection intensities are known. These formulas are available in standard texts.

He points out that selection against a rare recessive gene is very ineffective, unless there is some way of selecting against heterozygotes. For example, a 50 per cent reduction in reproduction of heterozygotes would reduce the incidence of the recessive homozygote under random mating to one fourth of its former value in one generation. On the other hand, even with complete selection against homozygotes, this might require hundreds of generations. Considering mutation, it may not be possible in any length of time.

In the case of selection against dominant genes, the results are more effective. However, very harmful and very rare dominants (which are likely to be very rare if they are harmful) may owe their incidence largely to currently arising mutations, in which case selection is to this extent ineffective.[6]

Recombinant DNA

One can sense an impending explosion of knowledge in molecular genetics. Questions that have remained unresolved because the available phenotypic data are imperfect seem about to be settled as we acquire detailed knowledge of the human and other animal genomes. Orkin and his co-workers have shown that it is now possible directly to visualize a genetic defect by observing the behavior of DNA fragments containing particular gene sequences in an electrophorectic field.[7]

The report provides an example of the use of some of the tools of recombinant DNA to detect hereditary blood defects from amniotic fluid by looking for the presence or absence of a gene containing instructions for production of hemoglobin.

In the reported studies this approach was used to demonstrate the absence of delta-beta-thalassemia in the fetus of a Turkish woman. Hemoglobin genes were detected by observing the behavior of DNA fragments containing specified gene sequences in an electrophoretic field.

Orkin believes that more refined analysis of globin genes in normal and thalassemic DNAs will provide important insights into the molecular genetics of hemoglobins and the underlying defects in other forms of thalassemia.[8]

Only a year or so ago, these studies "would have been considered to be among the purely hypothetical benefits to be derived from the application of the techniques of molecular genetics."[7]

Another group of scientists, who successfully produced somatostatin in E coli, has just announced the successful production of human insulin using artificial gene synthesis and recombinant DNA techniques in E coli bacteria.[9]

The great amount of knowledge about the major human transplantation genes coming from many centers of the country has the potential for making a significant contribution to diagnostic medicine and to the understanding of pathophysiology in the next five to ten years. The major transplantation antigen system, designated histocompatability locus antigen (HLA), has been found to have a strong influence on the immune response to several foreign antigens and to affect an individual's susceptibility to specific diseases. There are about 40 known diseases in which patient susceptibility is determined at least in part by the major transplantation antigen system.[10]

Finally, two Michigan pediatric geneticists, Roy D. Schmickel and Golder N. Wilson, isolated a gene from cultured human fetal cells and photograph this first human gene. They were awarded the Nobel prize for their work![11]

The profound effect that this type of research and the resulting therapy will have on the human gene pool is obvious.

Pharmacogenetics

The variable reactions of individuals to the same dosages of drugs have been termed idiosyncracy, hypersensitivity, allergy, or intolerance. Garrod first described various errors of inborn metabolism and suggested that the unusual reactions to drugs might be caused by genetically determined aberrations in metabolic pathways. In 1950 several "idiosyncratic" drug reactions, such as primaquine-induced hemolytic anemias and suxamethonium-induced prolonged apnea, were clearly explained on the basis of genetically determined enzyme deficiencies. These discoveries gave birth to the field of pharmacogenetics.[12]

The implications of pharmacogenetics are not of didactic but rather of great practical and clinical importance. Illustrative of this concept is the fact that shortly after the introduction of isoniazid (INH) patients were found to be either slow or rapid inactivators of the drug. The slow inactivators were found to be homozygous for an autosomal recessive genetic defect recognizable by the presence of a markedly diminished level of an hepatic acetylating enzyme necessary for INH detoxification. Rapid inactivators were found to be heterozygous. The importance of this finding is related to the fact that the most common side effect of the drug, peripheral neuropathy, was essentially confined to the slow inactivators.

Hydralazine, certain sulfonamides, and phenelzine are similarly detoxified. Therefore large doses or prolonged administration would be expected to produce toxicity in patients homozygous for slow activation. It was found that positive LE cell tests and antinuclear antibodies are much more common in slow inactivators of hydralazine.

There are many other drugs which have been incriminated. Although some have been reported only infrequently, others have a far greater clinical significance. In the latter group are G-6-PD deficient individuals with a frequency as high as 15 per cent in blacks in some parts of the United States. This is an extremely important cause of anemia in black males. This inherited abnormality illustrates the point that side effects can be caused by erratic behavior in susceptible individuals of drugs usually safely metabolized.

Many other drugs have been reported as having effects on genetically susceptible individuals. Present studies are directed to determining whether they are multifactorial or unifactorial inheritance. If unifactorial inheritance is found, this fact can be used to counsel other members of the family about the probability of a toxic reaction. Additionally, such defects are often amenable to chemical study, and it may be possible to pinpoint the exact genetic lesion.

If for some genetic reason a pregnant woman cannot metabolize a given drug, it may cross the placenta in larger than normal quantities and damage the developing fetus. Such facts emphasize the great importance of pharmacogenetics.[13]

A recent survey of drug therapy during pregnancy revealed that women take an average of 4.5 drugs during the period of gestation—80 per cent of which were self-prescribed. A small group of these patients took one or more drugs per day. This same survey documented a definite correlation between drug intake in pregnancy and the presence of congenital anomalies in the infants.[14]

The fetus will be reached by most of the drugs taken by the pregnant patient. The effect will depend upon the timing of administration, the posology, the length of administration, and the genetic response of the mother and fetus to the drug administered. It is known that the placental transport of maternal substances to the fetus and vice versa is established by the fifth week of embryonic life. Foreign substances cross the placenta by passive diffusion, depending on the gradient of concentration. Low molecular weight substances cross freely, but, with increasing molecular size, the degree of lipid solubility and ionization plays a more important role. Binding with plasma protein is also important, since only an unbound drug can cross the placenta. With the nearing of term, the ability of the placenta to metabolize drugs increases. It is of utmost importance whether the rate of transfer is great enough to produce sufficiently high drug concentrations to effect the fetus pharmacologically. In prescribing for the pregnant woman, one must not only consider the action upon her of the drug, but also be alert to the possible consequences to the fetus.[15]

In prescribing drugs during pregnancy, one must remember that the pharmacologic effects of a drug on the fetus may be different than on the mother. Teratogenic agents affect different organs during gestation at different times. Critical periods of teratogenesis in the fetus are between 15-25 days for the nervous system, 24-30 days for the eye, 24-36 days for the legs, and 20-40 days for the heart.

The discovery of new genes through pharmacogenetics, artificial gene synthesis, and recombinant DNA techniques, as used in the successful production of human insulin, could lead to correction of these defects. This could of course profoundly affect the genetic pool.

Selective Abortion and Its Genetic Effect

One method of handling inherited diseases is to prevent their occurrence. Amniocentesis makes possible the diagnosis of a relatively small number of inherited diseases. In cases where a fetus is at risk, an abortion can be performed. However, Morrow doubts that these procedures will greatly reduce the incidence of diseases for which they are practical. His reasoning basically is that amniocentesis will be done only after the marriage has already produced a diseased child. It is then obviously too late to reduce the incidence of the disease.[16]

Motulsky has stated that selective abortion does not appear to be the solution to eradicating genes causing autosomal recessive diseases, even if screening techniques for prenatal and premarital detection of all heterozygotes were to be developed. He reasons that the total number of these genes is higher by several orders of magnitude than the number of genes causing autosomal dominant diseases. Therefore, there would be a corresponding increase in the number of abortions. Another argument against selective abortion to eliminate genes causing rare autosomal recessive disease is the generally accepted fact that, on the average, every individual is a carrier of three or more such genes, and almost every human being carries at least one. Thus, the potential long-term effects of selective abortion on gene frequencies in autosomal recessive and X-linked recessive diseases are generally minor.[17]

This point was well illustrated by Kaback and O'Brien. A Tay-Sachs disease program was undertaken to study the implication of widespread heterozygote screening in a selected population, and providing a mechanism for reproduction even in at-risk couples. Questions were raised with regard to the possible effects of such a program on the gene frequency in the studied population. They calculated, with the Tay-Sachs program in mind, that, if all the Ashkenazic Jews in North America of child-bearing age were screened for this gene, and if all of the couples could reproduce two children without this disease, the overall effect would be a 'relative decrease' in the gene frequency of 0.019 per cent per 25-year generation. It is obvious then that thousands of years would be necessary for a change in the Tay-Sachs disease heterozygote frequency to be evident in the Ashkenazic Jews as a result of such a program.[18]

Irradiation and Its Genetic Consequences

Mechanisms which maintain the population frequency of genetically handicapped individuals have markedly increased in the last two decades. Selection has come to be considered more important and new mutation less so, with the result that the predicted effect of increasing the mutation is less than was formerly thought. One result is seen in the recently revised recommendations of the International Commission on Radiological Protection. Hereditary damage has ceased to be considered the overwhelmingly important effect of irradiation of human populations even when the whole body is uniformly irradiated and the radiation dose to the gonads is as high as in any other tissue. With uniform irradiation, as by caesium-137 or carbon-14, the frequency of induced cancer is considered to be larger than the frequency of induced hereditary damage. With most radionuclides of common concern, irradiation of the body is non-uniform, the radiation dose in the gonads is smaller or much smaller than the dose in other tissue, and induced hereditary damage therefore even less important as compared with induced cancer.

Muller, who initially demonstrated that ionizing radiation-caused mutation, has been the source of much anxiety and fear. However, the correctness of Muller's predictions have not been confirmed experimentally. Repeated observations on the drosophila and laboratory mammals using radiation exposures at a level sufficient to increase the natural mutation rate by a number of times have failed to show the predicted deterioration in the numbers of "fitness" of this population. This fact pertained despite the fact that irradiation was continued for more than 30 generations.

He also points out that no definite excess of hereditary damage has been found in children of Japanese bomb survivors in spite of an intensive search, an observation which indicates that the human species is not markedly more sensitive to radiation mutagenesis than laboratory animals.[19]

The possible genetic effects of irradiating tumors in children were studied by Lewis. He reported that the genetic defects of greatest concern following paternal irradiation were likely to be those caused by dominant mutations and unbalanced translocations, whereas following maternal irradiation chromosomal trisomies may be most important. These risks can be minimized by gonadal shielding and fractionation.[20]

Natarajan et al reported that there is prima facie evidence that exposure to low levels of diagnostic radiation produce severe genetic damage that is expressed in the child of the exposed person as leukemia and other diseases. It is estimated that, for about 1 per cent of the exposed persons who are affected by radiation, there is a fifty-fold increase in the risk of leukemia, and a five-fold increase in certain other diseases.[21]

Much is known about the effect genetically of irradiation on experimental animals, but we have little knowledge of such effect on human beings.

Environmental Effects

Environmental factors by definition act from outside the embryo. By eliminating them it should be possible to prevent the deleterious effects on the developing embryo. By controlling or removing these factors, we shall be able to prevent some of the most distressing and handicapping abnormalities of the human race.

Among chemical agents, the most notorious is thalidomide. However, there are others: alcohol, cigarette smoking, Coumadin®, cytotoxic drugs, diphenylhydantoin, mercury (organic salts), and tetracycline. Among physical agents are ionizing radiation and radio-iodine, and finally infectious agents such as cytomegalovirus, herpes simplex, rubella, and syphilis.[22] The control of these factors or agents is well within the realm of possibility, and efforts must be directed to accomplishing this end. These can be achieved by discouraging the use of drugs during pregnancy, minimizing exposure to radiation, discouraging heavy alcohol intake and cigarette smoking, and finally supporting rubella immunizations and the treatment of syphilis.

Genetic Engineering or Gene Therapy

Genetic engineering has been defined as the directed modification of the gene complement of a living organism, the synthesis of recombinant DNA molecules, and the introduction of the product into cells. Although the molecular biologist has made remarkable advances in genetic engineering, there has as yet been no practical application. One of the potentials of the molecular biologist is the treatment of inherited disease by the use of gene therapy.

In assessing the potential of gene therapy, Morrow has stated that only those monogenic defects causing biochemically defined lesions have in the foreseeable future any real chance of treatment by this method. Included in this group are sickle cell anemia, some thalassemias, hemophilia, the Lesch-Nyhan syndrome, and a few others. Orkin has recently published data which bring the therapy of thalassemias closer to accomplishment. Morrow, addressing the question of whether gene therapy may degrade the quality of the gene pool, believes that it would not do so any more than would conventional medical therapy in the treatment with insulin of juvenile-onset diabetes.

In reply to a question concerning the future development of gene therapy in human beings, Morrow stated "I can see three more or less separate breakthroughs that are really needed: (1) a way of isolating a set or a whole class of genes that we can't isolate at present, (2) a way of getting the DNA into a large fraction of the cells of the human being with reasonable efficiency (which I think is a problem), and (3) establishing the DNA so that it will continue to function and replicate in those cells. We don't know how long this will take, but I believe that it will certainly require a number of years."[16] This type of therapy obviously is in the distant future.

Clinical Cytogenetics

Human cytogenetics has become an important branch of medicine and human biology. Its importance is predicated upon the large number of persons affected by genetic disorders, and the importance of chromosomal changes in certain disease states.

Chromosome banding techniques are the most important method in the study of human chromosomes. These techniques allow differentiation of structures of the chromosome and improved localization of break points involved in translocation, inversion, and deletion.

The majority of chromosomal disorders arise de novo and are not the result of genetic transmission from one of the parents. At the present time, it is possible to determine maternal or paternal origin of each individual chromosome by using chromosome stains. The indication for parental karyotyping is the discovery of translocations, inversion, mosaicism, or deletion in the affected progeny. The importance of cytogenetics in Down's syndrome, the most common cause of mental retardation, cannot be overemphasized. Much of the data used in genetic counseling has been derived from these studies.

Genetic Counseling

This modality probably is best defined as in Fraser's description: "Genetic counseling is a communication process which deals with the human problems associated with the occurrence, or the risk of

occurrence, of a genetic disorder in a family. This process involves an attempt by one or more appropriately trained persons to help the individual or family (1) comprehend the medical facts, including the diagnosis, the probable course of the disorder, and the available management; (2) appreciate the way heredity contributes to the disorder, and the risk of recurrence in specified relatives; (3) understand the options for dealing with the risk of recurrence; (4) choose the course of action which seems appropriate to them in view of their risk and their family goals and act in accordance with that decision; and (5) make the best possible adjustment to the disorder in an affected family member and/or to the risk of recurrence of that disorder."[23]

The physician's role in genetic counseling is to insure the birth of unaffected children in those families which are at risk for genetic disease. Essentially, genetic counseling is the cornerstone of current genetic therapy, which helps families prevent the recurrence of serious genetic disease.

Summary

Defective genes not eliminated by the death or reproductive incapacity of the individual possessing them will remain to increase the overall frequency of these genes in the population and therefore, other things being equal, the number of affected individuals. What is not generally realized, however, is the extremely slow rate of this increase for most genetic diseases. For genetically dominant conditions, the increase would indeed be rapid. For example, in dominantly inherited retinoblastoma it can be calculated that, if all affected individuals could be cured (not an imminent possibility) and were to reproduce at a normal rate, the incidence of the disease, currently about 20 per million population, would increase sixfold in five generations, and 100-fold in a hundred generations. But dominant conditions account for only a small fraction of the really incapacitating genetic diseases. In the case of recessive conditions, the increase in incidence is far slower: in PKU, for example, under the same assumptions as above, the rise would be only 1 per cent of five generations and only 21 per cent of 100 generations—2,000 years or more.[24]

Howell put it in its proper perspective when he said: "A problem not infrequently raised in connection with the treatment of genetic disease is that successful treatment, by permitting affected individuals to survive and reproduce, will negate the natural process that regularly eliminates a proportion of the defective genes from the population. The result, it is held, will be a rapid increase in the population frequency of the gene in question and an even more rapid increase in the number of affected individuals who must be treated."

Summing up the current situation, it appears that there is little reason for alarm that there will be a dramatic upset in the human gene pool in the foreseeable future. Contrariwise, it appears from our present knowledge that it will proceed at a measured pace.

References

[1]Shaw MW: Genetically defective children: Emerging legal considerations. Am J Law Med 3:333-340, Fall 77.
[2]Holmes L: No specific cause in half of birth defect cases. Family Practice News 8:27, 1 Oct 78.
[3]Nadel J: Who shall live? Who shall be aborted? Who shall reproduce? Who shall die? Johns Hopkins Magazine: 13-17, May 73.
[4]Luy MLM: Genetic detection — the newest use of amniocentesis. Modern Med 42:31-35, 2 Sep 74.
[5]Karp LE: Novel mechanism of reproduction: preimplantational ectogenesis. Postgrad Med 64:77-80, Oct 78.
[6]Crow JF: Proceedings of the National Academy of Sciences 59(3):655-661, Mar 68.
[7]Nienhuis AW: Mapping a human genome, editorial. N Engl J Med 299:195-196, 27 Jul 78.
[8]Orkin SH, Nienhuis AW: Prenatal Dx of sickle cell anemia with amniotic cells foreseen. Family Practice News 8:57, 1 Nov 78.
[9]Buys D: Biochemists succeed in producing human insulin from bacteria. Med Trib: 3,25, 4 Oct 78.
[10]McDevitt HO: Diagnostic potential seen in transplantation gene data. Family Practice News 8:30, 15 Nov 78.
[11]First photograph of human gene. Med World News 19:20, 13 Nov 78.
[12]Motulsky AG: Drugs and genes. Ann Intern Med 70:1269-1271, Jun 69.
[13]Schimke N: Drugs and heredity. J Kansas Med Soc 70:146-50, Mar 69.
[14]Guillozet N: Drug risks in pregnancy revisited. J Fam Pract 4:1043-1052, Jun 77.
[15]Yaffe SJ: Drug use during pregnancy. Drug Therapy 8:137-146, Jun 78.
[16]Morrow JF: The prospect for gene therapy in humans. Ann NY Acad Sci 265:13-21, 1976.
[17]Motulsky AG, Fraser GR, Felsenstein J: Public health and long-term genetic implications of intrauterine diagnosis and selective abortion. Birth Defects 7:22-32, Apr 71.
[18]Kaback MM, Leonard CO, Parmley TH: Intrauterine diagnosis: comparative enzymology of cells cultivated from maternal skin, fetal skin, and amniotic fluid cells. Pediatr Res 5:366-371, Aug 71.
[19]Mole RH: Anxieties and fears about plutonium and other radionuclides, letter. Br Med J 1:46, 7 Jan 78.
[20]Lewis EB: Possible genetic consequences of irradiation of tumors in childhood. Radiology 114:147-153, Jan 75.
[21]Bross ID, Natarajan N: Genetic damage from diagnostic radiation. JAMA 237:2399-2401, 30 May 77.
[22]Aase JM: Environmental causes of birth defects. Continuing Education 3:39-40, 42, 45-46, Sep 75.
[23]Fraser FC: Genetic counseling. Am J Hum Genet 26:636-661, Sep 72.
[24]Howell RR: Genetic disease: The present status of treatment. Hospital Practice 7:75-84, Oct 72.

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Volume 63, Number 12

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Woodcut from the incunabulum "Hortus Sanitatis" by Joannes de Cuba printed in Mainz in 1491

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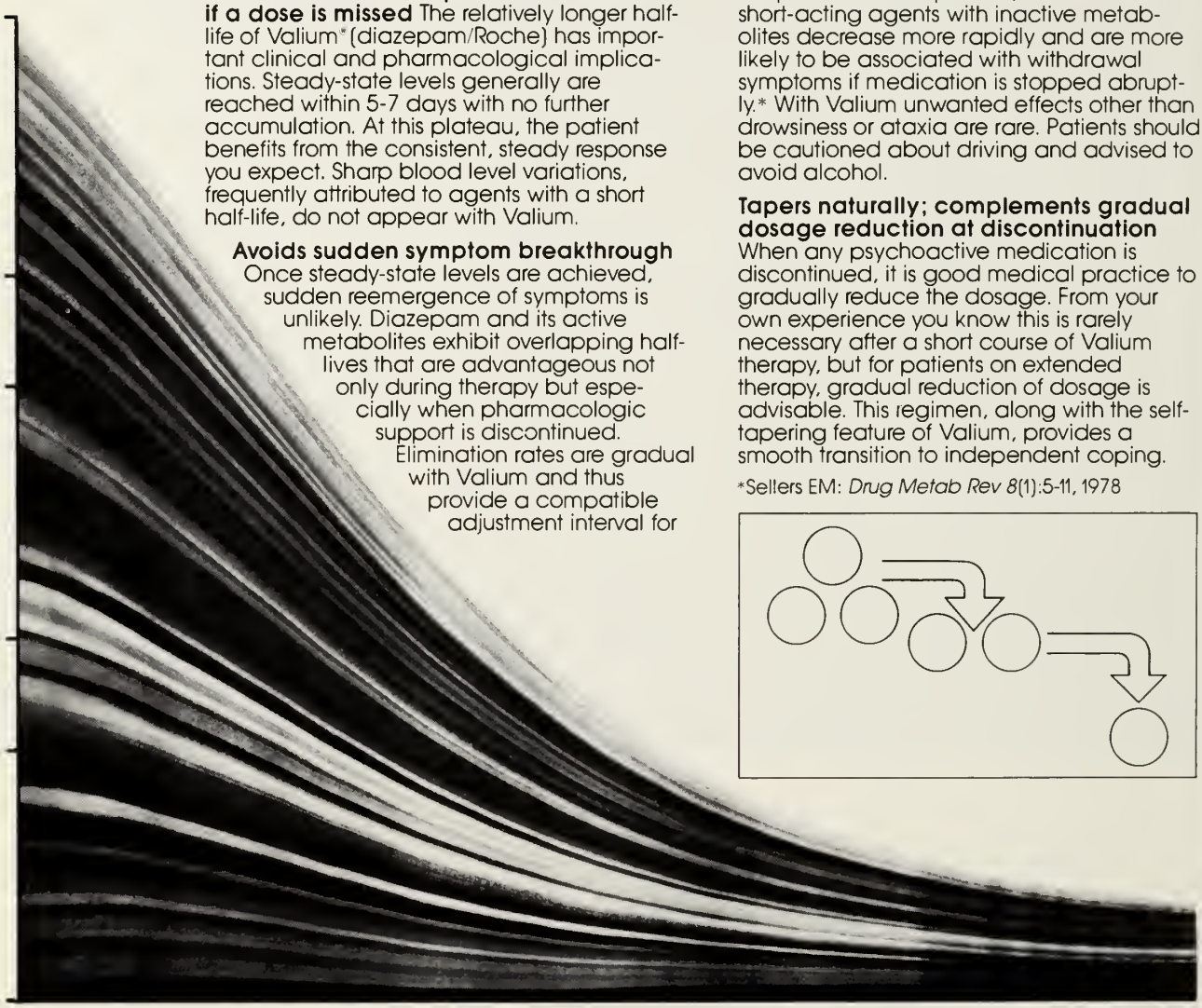

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For the staff and the members of the Rhode Island Medical Society I wish to express to the family of our close friend and partner our deepest sorrow over the loss of "Pete" from the profession.

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December 1980
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…nal classification of the less-than-…fective indications requires further …vesfigation.

…raindications: Glaucoma, prostatic hyper…y, benign bladder neck obstruction; hyper…tivity to chlordiazepoxide HCl and/or …um Bromide.

…ings: Caution patients about possible com…d effects with alcohol and other CNS …ssants, and against hazardous occupafions …ing complete mental alertness (*e.g.*, operat…achinery, driving). Physical and psychologi…ependence rarely reported on recommended …s, but use caution in adminisfering Librium® …rdiazepoxide HCl/Roche) to known addic-tion-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) reported following discontinuafion of the drug

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.**

As with all anticholinergics, inhibifion of lactation may occur

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude afaxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potenfiafing drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precaufions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patienfs receiving the drug and oral anticoagulants, causal relafionship nof established.

Adverse Reactions: No side effecfs or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilifated, avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered isolated insfances of skin eruptions, edema, minor mensfrual irregularifies, nausea and constipation, exfrapyramidal sympfoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after freatment, blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets

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Alpha Stimulation

Central Control of Blood Pressure*

"The Family of Man" by Roberto Moretti,
a statuary in crystal symbolizing the broad range of
hypertensive patients eligible for therapy with Catapres.

The Alpha Advantage:

It's for all kinds of hypertensives

- *Unlike beta blockers, Catapres® has no contraindications.*
- *Catapres can be useful even in these patients with:*

Congestive heart failure	Allergic rhinitis
Ventricular hypertrophy	Hepatic disease
Hyperglycemia	Hyperuricemia
Diabetes mellitus	Gouty arthritis
Bronchial asthma	Sulfonamide hypersensitivity

Like any antihypertensive, use with caution in severe coronary insufficiency, recent myocardial infarction, cerebrovascular disease or chronic renal failure.

work/play—normal hemodynamic responses to exercise maintained.

love—low incidence of impotence and/or loss of libido: 2.8% in 1,923 patients studied.[1]

cardiac output—tends to return to control values during long-term therapy.

blood flow—preserved in kidney.

No Single Advantage Determines Drug Choice.

Other factors must include:

The drug's effectiveness in a given patient, its side effects, warnings, precautions, tolerance, etc. A rational therapeutic choice depends on a careful assessment of all such factors.

*Central alpha-adrenergic stimulation decreases sympathetic outflow from the brain, as shown in animal studies.

1 Data on file at Boehringer Ingelheim Ltd.

Please see last page for brief summary, including warnings, precautions, and adverse reactions.

Now available in new 0.3 mg tablets

Tablets of 0.1, 0.2, 0.3 mg

Catapres®
(clonidine HCl)
Hypertension

The Alpha Advantage:

It's for all kinds of hypertensives

Tablets of 0.1, 0.2, 0.3 mg

Catapres®

(clonidine HCl)

Hypertension

- No contraindications.
- Effective in all degrees of hypertension. It is mild to moderate in potency.
- Low incidence of depression, impotence, orthostatic hypotension—no fatal hepatotoxicity.
- Preserves kidney blood flow.

Most common side effects are dry mouth, drowsiness, and sedation which generally tend to diminish with time.

The usual starting dose of Catapres is 0.1 mg at brea fast and 0.1 mg at bedtime. Some patients may bene from a starting dose of 0.1 mg at bedtime.

Usual daily dose range—0.2—0.8 mg

Maximum daily dose—2.4 mg
Doses as high as this have rarely been employed.

For optimal results, the dose of Catapres must be adjusted according to the patient's individual blood pressure response.

Catapres®
(clonidine hydrochloride)
Tablets of 0.1, 0.2, 0.3 mg

Indication: The drug is indicated in the treatment of hypertension. As an antihypertensive drug, Catapres (clonidine hydrochloride) is mild to moderate in potency. It may be employed in a general treatment program with a diuretic and/or other antihypertensive agents as needed for proper patient response.

Warnings: Tolerance may develop in some patients necessitating a reevaluation of therapy.
Usage in Pregnancy: In view of embryotoxic findings in animals, and since information on possible adverse effects in pregnant women is limited to uncontrolled clinical data, the drug is not recommended in women who are or may become pregnant unless the potential benefits outweigh the potential risk to mother and fetus.
Usage in Children: No clinical experience is available with the use of Catapres (clonidine hydrochloride) in children.

Precautions: When discontinuing Catapres (clonidine hydrochloride), reduce the dose gradually over 2 to 4 days to avoid a possible rapid rise in blood pressure and associated subjective symptoms such as nervousness, agitation, and headache. Patients should be instructed not to discontinue therapy without consulting their physician. Rare instances of hypertensive encephalopathy and death have been recorded after cessation of clonidine hydrochloride therapy. A causal relationship has not been established in these cases. It has been demonstrated that an excessive rise in blood pressure, should it occur, can be reversed by resumption of clonidine hydrochloride therapy or by intravenous phentolamine. Patients who engage in potentially hazardous activities, such as operating machinery or driving, should be advised of the sedative effect. This drug may enhance the CNS-depressive effects of alcohol, barbiturates and other sedatives. Like any other agent lowering blood pressure, clonidine hydrochloride should be used with caution in patients with severe coronary insufficiency, recent myocardial infarction, cerebrovascular disease or chronic renal failure.

As an integral part of their overall long-term care, patients treated with Catapres (clonidine hydrochloride) should receive periodic eye examinations. While, except for some dryness of the eyes, no drug-related abnormal ophthalmologic findings have been recorded with Catapres (clonidine hydrochloride), in several studies the drug produced a dose-dependent increase in the incidence and severity of spontaneously occurring retinal degeneration in albino rats treated for 6 mor longer.

Adverse Reactions: The most common reactions are dry mouth, drowsines sedation. Constipation, dizziness, headache, and fatigue have been rep Generally these effects tend to diminish with continued therapy. The foll reactions have been associated with the drug, some of them rarely. (In instances an exact causal relationship has not been established.) These in Anorexia, malaise, nausea, vomiting, parotid pain, mild transient abnormali liver function tests; one report of possible drug-induced hepatitis without and hyperbilirubinemia in a patient receiving clonidine hydrochloride, thalidone and papaverine hydrochloride. Weight gain, transient elevation of glucose, or serum creatine phosphokinase: congestive heart failure, Rayn phenomenon; vivid dreams or nightmares, insomnia, other behavioral cha nervousness, restlessness, anxiety and mental depression. Also rash gioneurotic edema, hives, urticaria, thinning of the hair, pruritus not asso with a rash, impotence, urinary retention, increased sensitivity to alcohol, dr itching or burning of the eyes, dryness of the nasal mucosa, pallor, gynecon weakly positive Coombs' test, asymptomatic electrocardiographic abnorm manifested as Wenckebach period or ventricular trigeminy.

Overdosage: Profound hypotension, weakness, somnolence, diminished sent reflexes and vomiting followed the accidental ingestion of Catapres (clo hydrochloride) by several children from 19 months to 5 years of age. lavage and administration of an analeptic and vasopressor led to comple covery within 24 hours. Tolazoline in intravenous doses of 10 mg at 30-r intervals usually abolishes all effects of Catapres, (clonidine hydrochloride dosage.

How Supplied: Catapres, brand of clonidine hydrochloride, is available as (tan) and 0.2 mg (orange) oval, single-scored tablets in bottles of 100 and 100 available as 0.3 mg (peach) oval, single-scored tablets in bottles of 100.

For complete details, please see full prescribing information.
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Boehringer Ingelheim
Ridgefield, CT 06877

Rhode Island Medical Society

December 1980

Newsletter

Peter L. Mathieu, Jr., MD, Editor
Karen Challberg, Associate Editor

Occupational Medicine Close-Up

Denis R. Baillargeon, MD*

Persistent dermatitis, aplastic anemia, adult-onset asthma, peripheral neuropathy, chronic liver disease, and interstitial lung disease — what do these conditions have in common? They are examples of diseases which may have as their etiology a pathological adaptation to one's working environment. They may be occupational diseases.

Many of our patients spend one quarter or more of their adult lives being exposed to various chemical, physical and ergonomic hazards in their jobs about which we as practicing physicians know little or nothing. The Department of HEW in 1970 *estimated* that there were 100,000 deaths a year in the United States directly attributable to occupational diseases and 390,000 new cases of occupational diseases a year. These figures may be grossly underestimated because they are based on those cases that are recognized as being due to a patient's occupation and reported as such. However, most cases are not recognized because the occupational hazards in question do not produce acute effects but chronic diseases that often have non-occupational etiologies, such as chronic bronchitis, cataracts, carpal tunnel syndrome, and hearing loss.

New diseases related to occupation are being announced regularly such as hepatic angiosarcoma from exposure to vinyl chloride, sterility among manufacturers of dibromochloropropane pesticides, and altered immune function among poly-brominated biphenyl-exposed farmers. The situation can only worsen since there are now about 15,000 chemical and physical agents in use in industry of which legal exposure standards exist for less than 500. With expanding technology more than 3,000 new chemicals are introduced each year, and the public is more concerned than ever before about the hazards posed by a seemingly endless list of substances.

Yet, the average medical student in the United States spends more time being taught about malaria than about the entire field of occupational medicine.

In 1946 the American Academy of Occupational Medicine was created to meet the educational needs of the full-time practitioners in the field. In 1955 the American Board of Preventive Medicine instituted the new specialty of Occupational Medicine. Today Occupational Medicine is a highly technical specialized field requiring extensive knowledge of toxicology, epidemiology, biostatistics, industrial hygiene, ergonomics, and clinical medicine as well as familiarity with a multiplicity of federal and state laws.

Every primary care physican practices occupational medicine whether he or she treats the ulcers of a company executive or the asbestosis of a man who has fixed brake linings for 35 years. At the same time, the public is more concerned than ever before about the hazards posed by a seemingly endless list of substances. All physicians hear questions from their patients about PCBs, kepone, vinyl chloride, lacquers, benzene, asbestos, heavy metals, fibers and dusts of every description. Furthermore, practicing physicians are being increasingly called upon to make difficult judgments as to whether a particular condition at the work site is potentially harmful, and whether harm has already occurred to an individual from such exposure.

You don't need to be board-certified in occupational medicine to recognize that someone found unconscious in a trichloroethylene degreasing vat may have an occupational disease, but when an asthma attack occurs at 3:00 am it may take some probing to find that the cause is an amine hardener that the patient used during the day at his work with epoxy resins.

Once a clinician *suspects* that an illness might be occupation related, the next steps are:

(1) *Obtain a detailed occupational history.* A history should include a description of the exact operation of the patient's job; the names and forms of the raw materials and intermediate products worked with; the availability and use of protective equipment; and materials used in nearby operations.

(2) *Determine if symptoms are related to exposure.* Does the reaction seen in the patient conform to known reactions of the suspected substance? Is the form of the substance the patient worked with capable of being absorbed? Does epidemiologic data document that groups of workers exposed to the suspected agent have an excess risk of the illness in question?

(Continued page 462)

RIMS • Membership Count • RIMS
(as of October 31, 1980)

Total RIMS members	1384
Total AMA members	826
New RIMS members	9

Joan Abar, DO
J. Jeffreys Bandola, MD
Donald Baxter, DO
Richard D. Brown, MD
Leonard F. Hubbard, MD
Mark Migliori (student)
Michael Migliori (student)
Philip Opalenski, MD
Hani M. Zaki, MD

Council Briefs

Meeting October 6, 1980

Peter L. Mathieu, MD,* Presiding

• Report of Management Committee the development of a point scale system for rating candidates and narrowing of the candidate pool for the position of Executive Director is in process.

• Voted to reject I.C. System, Inc. proposal for RIMS sponsored collection service.

• Voted to send the Chairman of the Child-School Health/Family and Children Services Committee to the AMA 17th National Conference on Physicians and Schools, November 12-14, 1980.

• Heard a report of Dr. Dario Herrera* on proposed "Conferences on Basic Aspects of Running" and voted to approve and defer action on RIMS participation until the proposal is considered by the Medical Aspects of Sports Committee.

• Heard a report by Mr. Joseph V. Shanley, partner in Duffy & Shanley, Inc. on a promotional program for pneumococcal vaccine and voted to endorse a statement that the vaccine has been "proved effective" and that it is recommended for use according to the "individual judgement by a physician depending on the needs of his patient".

• Heard a report by Dr. Kenneth Liffmann on meetings with the JUA and on his intention to help to improve the functioning of the state's mediation panels.

• Voted to approve the report of Dr. Charles P. Shoemaker, Jr.,* Chairman, Hi-Tech/Hi-Touch Committee, on RIMS "computerization" and authorized him to proceed to obtain bids.

• Voted to send Dr. David P. Hallmann,* Vice-Chairman, Educational and Scientific Board, to the Eighth Annual Conference on Continuing Medical Education, October 30-31, 1980.

• Heard and voted to approve the report of Dr. Erminio Cardi, Treasurer.

• Heard a report by Dr. Richard W. Perry,* President of the Rhode Island Cardio-Thoracic Surgical Society on the recent decision of The Miriam Hospital to close its cardiac surgery unit, and voted to send a letter of inquiry to the Director of the Rhode Island Department of Health regarding this problem. (See "RSVP . . .") ■

Occupational Medicine Close-Up *(continued)*

(3) *Document exposures.* Employer maintained medical and exposure records should be obtained (with written consent from the patient), and specific laboratory tests for an agent or metabolite may be done on the patient's blood (eg, lead), urine (eg, hippuric acid for toluene exposure), hair (eg, mercury), or lung biopsy material (eg, asbestos, silica).

Based on final diagnosis, appropriate recommendations to the patient for adjustments in his/her working environment, use of protective devices or removal from the job are the physician's prerogative and responsibility. ■

RSVP . . .

RIMS wants to know . . .

Joseph E. Cannon, MD
Director
Rhode Island Department of Health
75 Davis Street
Providence, Rhode Island 02908

Dear Dr. Cannon:

Many members of the Rhode Island Medical Society h expressed their concern with the presently existing state of carc surgery services in Rhode Island.

As you know a leading cause of death in our state is h disease, and open heart and bypass surgery lower this morbidity mortality. Performance of open heart surgery in a hospital gre benefits other aspects of care in an institution. Because of advanced body of knowledge and sophisticated techniques involv open heart procedures require heart lung machines, monitor devices and many ancillary persons and they are very costly.

The Rhode Island Medical Society is deeply cognizant of great cost dilemma in many aspects of patient care, as you are. In balance, however, availability must be a first priority.

I have been directed by the Council of the Rhode Island Med Society to write to you concerning the status of the "open h surgery" program at The Miriam Hospital.

Since you are more familiar with The Miriam Hospital det than I am, I am taking the liberty of asking some questions which Council requested be answered:

1) Does The Miriam Hospital have a certificate-of-need for t services program in open heart surgery and "cardiovascular thoracic surgery", and what are their commitments and respo bilities?

2) What is the present status of open heart surgery in Rh Island, in view of the fact that this program has been discontinue at The Miriam Hospital? Can other hospitals initiate open heart sur programs at this time, and if so, how must they proceed?

3) As a physician, I ask you, is it legal for physicians as a gr to be denied the right to practice their specialty in an institution w has made a community commitment to that service?

The issue is of grave importance. I, for the physicians in Rh Island, look forward to the favor of your reply.

Sincerely yours,
Peter L. Mathieu, Jr., MD
President
Rhode Island Medical Society

Obfuscation by Planning?

SHCC Plan Says . . .

". . . it seems unlikely that the numbers of RNs projecte seek employment in nursing in Rhode Island during the n fifteen years will all find jobs . . . While the numbers curre available for forecasting the numbers of RNs that will required in future years are relatively unsophisticated it seems likely that without policy intervention, the supply RNs seeking employment in nursing may greatly exceed number required by employers."

A Fact in the Matter Is . . .

". . . licensed practical and registered nurses (are be sought) to fill jobs at the General Hospital, Institute of Me Health and Alcohol Detoxification Unit, all at the Med Center in Cranston; and also at the Ladd Center in Exeter; Zambarano Hospital in Burrillville . . . Department offic said that while they would like to fill all the vacancies, t would consider the program a success if they were able to add 50 nurses to the staff. Officials said there is inte competition among hospitals to hire nurses, and that m hospitals in the area also are trying to recruit nurses." *(Providence Journal)*

Interview of the Month:
Pierre M. Galletti, MD

Dr. Pierre Galletti's research specialty is "substitutive" (or "spare parts") medicine, to which he brings, also, a sure and insightful overview of how the field impacts on the whole picture of medicine.

Today it is possible to implant in the human body a variety of donor organs or man-made devices in substitution for or to assist a person's own damaged organs. Prosthetic cardiac valves, cardiac pacemakers, artificial kidneys, prosthetic arterial grafts, and lens implantations are only a few examples of available devices and procedures. "Many procedures which are just now being perfected may well become *commonplace* in our lifetimes," says Galletti.

The development of these devices poses challenges. Use of them may be accompanied by secondary symptoms. For example, a person with an artificial assistance system may develop metabolism problems. Also, there are potential psychological side-effects. A patient may become resentful because of discomforts and dependencies caused by requirements for regular check-ups and maintenance for artificial organs.

Then there are ethical, legal, and cost problems. Under what circumstances is it a person's *right* to receive a particular implant, and *who will pay for it?*

Discussions on the latter issues will continue for years, but Dr. Galletti's prognostications for resolution of them are optimistic. In the mid-1960s, he recalls, Dow Chemical Company discovered a way to make hollow fibers of cellulose for artificial kidneys, and estimated the cost for the part at $400. Today, these sell for $18. "Projections of cost are no better than the assumptions on which they are based," says Galletti, "and assumptions may be wrong."

Pierre Galletti was born in Monthey, Switzerland, and earned MD and PhD degrees at the University of Lausanne. In 1957 he moved to Los Angeles and became a postdoctoral research fellow at the Cedars of Lebanon Hospital. The next year he became assistant professor of physiology at Emory University in Atlanta, where he worked for ten years, except 1964-1965, which he spent as Eleanor Roosevelt Fellow of the International Union Against Cancer at the University of Palermo, Italy. In 1967 Galletti came to Brown University, attracted by Brown's engineering department and the possibilities for connections in research between that discipline and the medical sciences.

At Brown, Galletti served first as chairman of the Division of Biological and Medical Sciences, and then, since 1972, as vice president (biology and medicine). There is a compatibility between his research and his administrative goals. As Galletti views the future, he foresees a new historical era for medicine in which devices will regain importance, and reliance upon drugs become much less than it is now. Translated in terms of administrative action a significant component of medical training, particularly in certain specialties (orthopedic surgery, for example), must become more technological training.

This new technology, in turn, is influencing health planning. At the present time concerned parties in legal, academic, government, and industry sectors all agree that the least desirable outcome for society as a result of new medical achievements in the transplant line would be the rationing of devices. No one should be excluded from the new benefits. One direction, Galletti suggests, is rating devices on their merits in terms of medical/service costs. One of the criteria for an acceptable, marketable device might be, for example, low service/maintenance requirements. Another might be a mode of production to employ relatively unskilled personnel, or the previously *un*employed. In any case, costs and benefits of devices must be studied *prior to* initiation of marketing strategies for them.

Spare parts medicine is exciting and imaginative, and at the same time demands consummately down-to-earth skills. It can sound like science fiction, and all the while it's really happening.

The story as it unravels is told in part in the "Journal of the American Society of Artificial Internal Organs", of which Dr. Galletti is the editor. Some of the intriguing titles in this magazine, now in its second year of publication, include "Species Differences in Platelet Adhesion to Biomaterials: Investigation by a New Two-Stage Technique" and "Combination of Sulphinpyrazone Pretreatment with Denucleation Priming for Membrane Oxygenator Perfusion in Sheep". ■

RIMS • CHRISTMAS PARTY • RIMS

Members, Wives, Friends Welcome

December 16, 1980

6:00 P.M.

Residency Training in General Internal Medicine

Milton W. Hamolsky, MD,* Physician-in-Chief Steven A. Wartman, MD, Program Director

The Department of Internal Medicine at the Rhode Island Hospital has a separate training program in General Internal Medicine. The goal of this program is the training of residents for the practice of general internal medicine with a primary care orientation. These residents will have a broader and deeper experience in ambulatory care, in addition to training in subspecialty internal medicine and the care of hospitalized patients.

The curriculum is specially designed to integrate the behavioral, preventive and psycho-social aspects of health with illness care. The core faculty consists of general internists who serve as role models, preceptors and teachers. The three-year program consists of 15 months of in-patient care, 7½ months of subspecialty electives, 4 months of Emergency Room medicine, and 7 months in ambulatory block time.

The ambulatory block experience (divided equally among the three years) provides the resident with an intense exposure to primary care-oriented internal medicine similar to office practice. During this time, the resident also has regular rotations in selected other specialties such as gynecology, orthopedics, opthalmology, and ENT.

Besides continuing supervision provided by faculty preceptors, teaching and case conferences, each resident participates in a series of didactic modules covering relevant issues in patient care management, epidemology, public health, behavioral and social science, and health services research.

All residents have responsibility for maintaining continuity clinic during all three years of the program. In addition, residents are able to maintain continuity of care when their patients are admitted to the hospital by either taking care of the patient directly or consulting with the House Staff involved.

Four positions are offered each year at the PGY level. In selecting candidates for this residency track the following special qualifications are stressed: 1) The applicant's intent to practice general internal medicine or to enter a career in academic general internal medicine. 2) Demonstrated proficiency in patient care and management as evidenced by letters of support. 3) Demonstrated ability in interpersonal skills and awareness of important primary care/general internal medicine issues, including the concepts of continuity and coordination of care and appreciation of the psychosocial aspects of health and illness behavior.

The program, presently operating with funding from the Department of Health and Human Services, is gradually building self-sufficiency. The future is promising, as it addresses through its ambulatory emphasis the need for cost containment strategies in the delivery of medical care. To provide primary care physicians trained to meet ever emerging needs for adult general medical services within the complex system of specialties is the program's goal. (See Contribution: "Increasing the Yield of Primary Care Oriented Practitioners from Residency Programs in Internal Medicine", page 483.)

RI's IPA: Update

The physician interest in developing the Ocean State Master Health Plan continues to grow. This is evidenced by the more than 400 physicians affiliated at mid-October. Concurrent with this phase of development, the Plan is seeking its Certificate of Need (CON) and license required by the Department of Health. The initial phase of the CON review is conducted by the Project Advisory Committee of the Health Planning Council. In its October report to their Board of Directors, the Review Committee concluded "the proposal of the Ocean State Master Health Plan to establish an individual practice association health maintenance organization (IPA-HMO) to be in the public interest." The entire review process is expected to be completed in December, with the final decision to be rendered by Dr. Joseph E. Cannon,* Director of Health. ■

Functional Facts Help RIMS Serve Members

The more RIMS can find out about Rhode Island physicians, the better it can 1) represent their interests, 2) serve public information needs, and 3) undertake significant health manpower planning. The new combined Rhode Island Department of Health 1980 Physician Relicensure Survey and Rhode Island Medical Society Information Roster form is an expanded improved version of its predecessors. In aggregate Rhode Island physicians are a very impressive team. By physician compliance with the next relicensure request for information we'll be able to tell the story with the facts. This administration urges your compliance.

Administrative Reports . . . Meetings with Officers and Staff

Wednesday, October 8, 1980 . . . guests of the meeting were Mr. Donald C. Williams, Supervising Health Planner, Rhode Island Department of Health; Mrs. Brenda Pukas, Administrator, Wood River Health Services, Hope, Rhode Island; and Dr. Paul T. Welch,* Secretary-Treasurer, Rhode Island Neurosurgical Society . . . discussed and refined a physician relicensure survey/Rhode Island Medical Society roster combined information form . . . Dr. Welch presented concerns of his society as to whether malpractice insurance covers physicians sitting on a peer review panel and proposed that the Society consider legislative action to provide for immunity for physicians serving on such panels . . . reviewed miscellaneous business correspondence.

Wednesday, October 15, 1980 . . . heard staff reports of Lou Buckham, bookkeeper; Howard E. Lawton, Assistant Executive Director; and Karen Thallberg, Assistant Executive Director . . . reviewed miscellaneous business correspondence . . . Dr. Armino Cardi reported on his program for sorting out RIMS finances and preparing a budget for 1981.

Wednesday, October 22, 1980 . . . guests of the meeting were Francine Robbins, Director of Long-Term Care, Rhode Island Professional Standards Review Organization (RIPSRO); also Dr. Lewis Arnow, Chairman, Educational and Scientific Board . . . Dr. Arnow reported on efforts to develop a centralized state data reporting system for CME . . . Francine Robbins shared views with officers and staff on the nursing home shortage problem . . . discussion suggested possible ways present nursing home regulations might be revised.

Wednesday, October 29, 1980 . . . Dr. Paul B. Metcalf* chaired the meeting in the absence of the President, Dr. Peter L. Mathieu, Jr.* . . . reviewed recommendations to be presented to the next meeting of the Trustees of the RIMS Building . . . heard staff reports . . . reviewed recommendations received with relation to the Annual Implementation Plan, comments to be forwarded to the Rhode Island Department of Health.

Wednesday, November 5, 1980 . . . guests of the meeting were Mr. Donald C. Williams, Supervising Health Planner, Rhode Island Department of Health and William J. Waters, PhD, Assistant Director, Rhode Island Department of Health . . . Dr. Melvin Hoffman* reported on a meeting with Dr. Stephen J. Hoye,* Chairman, Board of Medical Review, on the subject of cooperation between the Board and the Society's three peer review-related mechanisms (mediation, peer review, and impaired physician programs); RIPSRO and Blue Shield efforts were also included in preliminary discussion of cooperative strategies . . . reviewed with Dr. Waters and Mr. Williams the final form of a new combined 1980 Physician Relicensure Survey and Rhode Island Medical Society Roster form . . . heard staff reports on work efforts of the previous week . . . reviewed miscellaneous business correspondence. ■

Meet the Presidents

It is unusual that a physician-employer and his medical assistant would simultaneously and coincidentally hold the office of president of their respective professional associations. To our knowledge, this is the first time in Rhode Island.

Dr. Daniel Moore, Jr., MD, currently president of the Providence Medical Association (PMA) shares this leadership honor with his medical assistant Mrs. Jacqueline T. Harker, President of the Providence Association of Medical Assistants (PAMA)

As physician-employer, president of PMA and as one of the three active physician-advisors from PMA assigned to PAMA, Dr. Moore is continually exposed to PAMA aims, interests and activities. Conversely, as medical assistant to Dr. Moore, Mrs. Harker is involved with PMA affairs. Oftentimes, it is Jackie's voice over the telephone in behalf of PMA, gently chiding and

successfully urging physician-members to turn out and attend a planned function. This unique dual situation affords an ideal opportunity for significant furtherance of inter-appreciation and understanding through continuous contact between these two associations. ■

Rep. Ann H. Hanson

Ann H. Hanson of Barrington, wife of Dr. Daniel J. Hanson* ("Jim") now holds Representative seat for District 88 in the General Assembly. Ann is past President of the Barrington League of Women Voters, and has served six years on the Barrington Town Council, during the last two of which she was president of the Council. Dr. Hanson is a member of the Rhode Island Medical Society and has served on several committees of the Society. ■

Aches and Pains . . .

• The 1980 voluntary hospital expenditure guidelines are compatible with the 1980 goal set by the health care industry last December, according to Paul W. Earle, Executive Director of the Voluntary Effort to Contain Health Care Costs (VE). Since the establishment of the VE two and one-half years ago, efforts by the industry have saved the American public more than $3 billion; physicians have kept fee increases several points below the Consumer Price Index.

• A California law authorizes health facilities to establish conditions by which clinical psychologists may hold membership and serve on committees of the facility's medical staff and carry out responsibilities consistent with the scope of their licensure. The law further provides that if a health service which both licensed physicians and surgeons and clinical psychologists are authorized by law to perform is offered by a health facility with both licensed physicians and surgeons and clinical psychologists on the medical staff, such services may be performed by either, without discrimination.

• The American Occupational Medical Association announces the publication of an up-to-date catalog listing more than 200 articles and reports about the health of workers which are available from the Association, the nation's largest society of occupational physicians. To obtain a free copy of the AOMA Publications List, send name and address to: AOMA Publications List, American Occupational Medical Association, 150 North Wacker Drive, Chicago, IL 60606.

• "The director (of the Rhode Island Department of Health) is authorized to enter, examine, or survey at any reasonable time such places as he considers necessary to carry out his responsibilities under this chapter or under other provisions of law. Any person who wilfully impedes or obstructs an inspection, examination or survey by the director shall, upon conviction, be punished by a fine of not more than one hundred dollars ($100) or by imprisonment for not more than thirty (30) days or both." *(General Laws of Rhode Island*, 23-1-19).

• The Office of Technology Assessment has re leased what it calls a major report on "The Implication: of Cost-Effectiveness Analysis of Medical Technology. The principal finding of the report is that the cost-effec tiveness analysis (CEA) and cost-benefit analysis (CBA of medical technologies should not be the primar determinants of decisions concerning health care. OT/ also concluded that cost-effectiveness and cost-benef analyses "will not be an effective tool for reducing o controlling overall expenditures for medical care." The OTA report is must reading in that it analyzes the pc tential for government expanding the use of CEA/CB in at least the following health care programs: (1) cove age under Medicare and Medicaid; (2) health planning (3) (FDA) market approval for drugs and devices; (4 PSRO; (5) R&D activities; and (6) HMOs. The report re iterates the legitimacy of the concerns about optimur spending of the nation's limited health care dollar raised by those who requested the study on the Senat Finance and Labor and Human Resources Committee: The OTA press release summarizing the report direct acknowledged the *rationing* effect that must inevitab result "in the case of allocation decisions made withi a budget . . . ." The logical result — ". . . the project that promise to deliver more benefits for the co: should be more attractive than those expected t deliver fewer benefits."

• Delaware has enacted a law this year imposir mandatory jail sentences for persons convicted of di tributing drugs to persons under 16 years of age. The: is a longer minimum jail term where the distribute drug is a narcotic and/or where the minor is under years of age.

• A helpful new booklet, *A Guide To Home Heal Care* by Alan Nourse, MD, is available free to peop who want to learn about more comfortable and le costly alternatives to hospital and institutional ca The American Medical Association reports that "rece studies have cited home health care as being an iden fiable cost-containment strategy and an essential co ponent of the health care delivery system." A copy the booklet can be obtained by sending a request t gether with a stamped, self-addressed business en lope to: Upjohn Health Care Services, Dept. 711, 36 Van Rick Drive, Kalamazoo, MI 49002.

Medical Meetings

DEC. 1980							
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December

1 Rhode Island Medical Society Council; regular meeting; 6:00 pm

2 SPARI Annual Meeting; dinner meeting; Cranston General Hospital (David Hallmann, MD* will host AMA speaker on hospital relations)

2 Providence Surgical Society; regular meeting; Squantum Club

2 RIMS — Impaired Physicians Committee; meeting; RIMS Library; 7:30 am

3 RIMS Interim Meeting (David Hallmann, MD,* Chairman will host AMA speaker on hospital relations)

5 Organization of State Medical Association Presidents (OSMAP); regular meeting; San Francisco

7-10 AMA House of Delegates, Interim Meeting; San Francisco

10 New England Pediatric Society; regular meeting

10 The Ted Chmura Symposium on Cancer; RIDH Auditorium; co-sponsored by RIMS; 1:00-4:15 pm

11 RIMS — Blue Shield Liaison Committee; meeting; RIMS Library; 7:00 pm

12 Pawtucket Medical Society; Christmas Party; Agawam Hunt

15 Blue Shield Board; regular meeting; 6:00 pm

15 RIMS — Committee on Aging and Committee on Delivery of Medical Care; joint meeting; RIMS Library; 7:00 pm

16 RIMS Christmas Party; 6:00 pm; (p sentation of district society charters a past presidents gallery showing)

January

20 RI Society of Pathologists; quart scientific meeting; Women and Infa Hospital; 8:30 pm

21 RIMS House of Delegates; regular m ing; RIMS Auditorium; 2:00 pm

February

16 Rhode Island Medical Society Cour regular meeting; 6:00 pm

19 RIMS — Blue Shield Liaison Commit meeting; RIMS Library; 7:00 pm

23 Blue Shield Board; regular meeting

PRESIDENT'S CORNER

Insurance: They All Look Alike Are They? Part II

Anyone calling the insurance industry *"blood-bundling"* does not see clearly the problem. Even before the malpractice crisis of 1974 and 1975, for years insurance companies were discussing the basic problem of the cost of malpractice insurance. The companies admit that they do not have a handle on the cost problem, and certain basic reasons for this are now evident. First, state insurance regulators have failed in their data collection efforts. With malpractice insurance lumped by insurance companies together with all other types of liability insurance, the actual claim experience of the companies provides no reliable information. The profit or loss situation of the malpractice business is in a fog. A study done by the National Association of Insurance Commissioners in 1975 and 1976 revealed that the average loss per physician for malpractice claims settled was $686. In the same year malpractice insurance profits by the insurance companies rose 20.1 per cent.

In addition to the many "seat of the pants" or "intuitive" causes given by the insurance companies, the real basis for the malpractice crisis of 1975 lay in the economic recession of 1974 and 1975. The real basis for the *continued* problems in malpractice insurance lies in the inability of the insurance companies to get a real handle on their experience with this product. They just do not know what profits, if any, they are making in this line. They do know, however, that their costs are increasing, and this upsets them. The time has come for the regulators to regulate more closely if the consumer, which includes the physician, is to continue to obtain a reasonably priced product vital to the health care stability of the community.

Insurance companies invest surplus funds in the stock market; surplus funds possibly decline but *certainly* fluctuate. In addition, premiums paid by health care providers once a year are used to pay for claims that arise in that year, but may be settled two to four or more years hence. Claims are paid by investing the premiums in any one year and using the interest on that premium to pay for the eventually settled claim, but since, however, reserves of surplus funds may fall with the fall of the stock market, "crises" can occur.

Peter L. Mathieu, Jr., MD

The insurance system, faced with losses of billions of dollars (4.4 billion dollars in 1975), decided that malpractice insurance rate risks were too great. Faced with losses, insurance companies withdrew from the malpractice arena entirely, rather than escalate the premium cost beyond the reach of the health care providers. Is this posture in the best interest of the community, and has the time come for the insurance industry to obtain outside help to assist it in putting its house in order?

It is an all-too-widely held belief that medical malpractice insurance is profitable because the invested income earned on the premiums is held for as long as ten years before losses are settled. Certainly, a considerable amount of investment income derives from the cash flow generated by medical malpractice insurance premiums. However, the ratio of claims pending for every doctor has risen from a ratio of one claim pending for every twenty-three doctors insured in 1969, to one in ten in 1975. The national claim frequency in physicians' service policies issued in 1965 was 1.74 claims per 100 physicians. In 1972 the ratio was 4.15 claims per 100 physicians. The average cost of a claim skyrocketed from $6,705 in 1969 to $12,534 in 1974. The terrifying trend of increasing claims costs, as well as the increased number of settlements for more than one

million dollars between 1973 and 1979, has worried the insurance companies and places right in their laps the problem of keeping premiums in line with these trends. Yet past patterns of claim experience have invariably been inadequate to forecast future expectations.

Under claim "occurrence" policies, the most common for medical malpractice insurance, the doctor is insured for any claim that might arise in the future as a result of an incident that occurred during a year the policy was in force. Thus, 10 or more years may pass before all the medical "injuries" become reported claims. Even after claims are reported, it may be many years before settlement. This characteristic of claim settlement many years after a malpractice incident is the so-called "long tail" of medical malpractice insurance.

The long time lag between the policy year and year in which claims are settled presents a challenge to the rate making authorities in the insurance industry. This problem is compounded by the fact that, during the long interval, there may be rapid changes in technology, economic conditions, social climate, and legal interpretation. The insurance industry has never underwritten a line of business that poses more problems for rate making than malpractice policies.

The Rhode Island Medical Society has been informed that the Joint Underwriting Association (JUA) is currently filing for a 25.3 per cent rate increase for malpractice insurance coverage. A prehearing conference has been held. At this conference this administration with legal council represented the Rhode Island Medical Society. The Department of Business Regulation and the Attorney General's office were represented, also, with actuaries. During the hearing some very interesting questions were asked. The JUA representative responded with data based on other than the Rhode Island experience, using figures supplied by National Insurance Organization of America (ISO).

The trend item was questioned. There seemed to be nothing in the refiling to support this upward alteration of rates, especially since the JUA acknowledged that the Rhode Island frequency trend may not be credible. The Rhode Island JUA, not comfortable with the available Rhode Island data, has yet to put together a system to improve it. National ISO data shows a downward trend frequency, but the JUA says this is outdated (1976). JUA participants are asked to take the association's statement of an upward trend on "faith".

Another question asked was whether JUA expenses are variable or fixed. The JUA reported their expenses to be 12 per cent of premiums. JUA has an administrative contract with American Universal Insurance Company for 5¾ per cent of premiums.

At the hearing the JUA indicated its belief that mediation panels give rise only to "double-trials". The JUA pointed out that hospital experience provides faulty claims data and that there are no good figures for doctors' experience. The JUA persistently refers to the Rhode Island experience, but its figures, supplied by ISO, continue to be based on the national experience. The JUA doesn't have a count of Rhode Island doctors actually insured, nor does it have an exposure count by specialty. It does report that there are five risk classifications used for premium rate setting for physicians. It was pointed out to the JUA that we are extremely interested in exposure data, only, not necessarily premiums paid or losses. The JUA has been asked for incurred losses, incurred claims, and incurred reporting data for Rhode Island. However, most of the statistics applied by the JUA in filing for a rate increase were national excluding California and parts of New York. The JUA has no data of its own more recent than 1978 to report. The JUA claims that filing materials were prepared in May 1980. Criticism is certainly to be expected when an insurance company files for a rate increase in 1980, using 1975 data (ISO).

The JUA responds by saying that every claim since its inception has been reported to the Director of Business Regulation.

In discussions of the investment discount factor, countrywide base data are used, because, the JUA reasons, its experience is affected by delays in the mediation panels, and because this slowness prevents a true rate loss ratio factor for Rhode Island. The medical society has expressed its concern about this in the past and will continue to exert pressure for better information. The mediation panels had 225 cases assigned as of May, 1980, with only 11 panels making recommendations to date. A mediation panel under the statute consists of two attorneys, one a master, and a medical doctor in the specialty pertaining to the case to be heard. The JUA blames both the doctor who wants the meetings in the evening and the lawyers who work during the day. In sum, unable to get a breakdown rate claim amount paid for Rhode Island from JUA, JUA continues to talk about ISO data.

In discussions of incurred loss development for the years of its existence, the JUA stonewalls. This administration has asked the chairman of the JUA for more Rhode Island information to satisfy

concerns of the Society and the physicians in Rhode Island. The JUA and actuaries involved with it during the last five years have repeatedly stated that it takes about five years for an insurance company to develop a true rate experience and reportable credible data. Since the JUA started in 1975 and it is now 1980, this administration wonders when this credible experience reporting will be forthcoming.

To develop credibility, the Rhode Island medical malpractice experience must be ascertained. The number of claims per year, incurred losses, and arising claims and open claims experience in Rhode Island, should give some insight into the loss activity of the Rhode Island JUA.

The process of tracking claims activity is a continuing responsibility of the JUA. This administration asks the JUA in which specialties are we seeing increasing numbers of cases, and in which specialties are we seeing increasing numbers of claims? This administration stresses the importance of each physician advising the JUA, as soon as practical, of any untoward or unexpected results in the management of a patient. This is a contractual obligation. An individual physician's premium does not rise with a reported claim. Delay hampers investigation and evaluation of claims due to fading memories and possibly inadequate records. The result is higher cost in disposition of claims due to the time lag and inflation. We urge the individual doctor to help control losses and decrease premiums by reporting problems to the JUA immediately.

One way to avoid the dilemma of either providing potentially self-damaging information, or losing insurance coverage, is to speak only to a lawyer retained to investigate and defend lawsuits. Your statements to such a lawyer are protected by attorney-client privilege. A physician is walking a thin line between avoiding giving self-damaging information to the insurance carrier, and avoiding omissions that can be obtained and used by the plaintiff. As long as liberal discovery rules are in effect, physicians should remember that the insurance investigator, like the policeman, is your friend, but anything you say to him may be used against you in a court of law.

When a physician is notified that he is being sued for medical malpractice, his first step should be to notify his insurance carrier of the impending action. Remember that the attorney assigned to you in a malpractice case is not necessarily your attorney. Interestingly, on all the legal motions filed, the lawyer is listed as the attorney for the physician and never as the attorney for the insurance carrier. Yet, whom does he represent and whose lawyer is he? I suggest that you ask the attorney point blank: "Whom are you representing?" Let him set down in writing that he is your attorney and not the attorney for the insurance company. If he finds his loyalties torn and he can't represent you, then he should withdraw from the case.

Contingency fees sound much like splitting of fees, and in medicine fee-splitting is unethical. I should like to see the plaintiff attorney's fee paid on a different basis. Instead of guaranteeing a daily fee that increases total costs the moment the case continues, I would prefer a set total fee, with "out-of-pocket" expenses subtracted from that.

Efforts at tort reforms have had an impact in some areas of the country, notably in California. By bringing together members of the Ad Hoc Committee on insurance with physician members of the JUA Board of Directors and forming the Insurance Committee of the Rhode Island Medical Society, this administration hopes to stimulate new legislation to change the common law to make the medical malpractice dilemma more manageable. Our desire is for a situation equitable for all. Among measures that should be considered is a "collateral source" provision that would prevent a plaintiff from collecting an amount equal to the cost of health care as part of compensatory damages if this amount has already been paid by a third-party carrier. Legislative activity might be undertaken also to provide for medical malpractice judgements to be satisfied by structured settlements and periodic payments. The intent here would be to revert funds in the event of death and to prevent windfall profits to others than the patients.

The state mediation panels have not been working. Therefore the Board of Medical Review must weed out incompetent physicians quickly and effectively. The JUA must provide prompt arbitration to avoid over-long delays (presently up to seven years) for the patient having a just claim, and to avoid the high cost of court trials. We should create "specialty courts" to deal with medical liability cases, similar to those presently existing for family cases, for divorces, and for adoptions.

Peer review is the single most effective tool to assess practical aspects of the impact of patient injury on loss dollars paid under the program. It provides the opportunity to evaluate a physician's witness potential, as well as his ability to defend himself before a unique forum—the jury of his peers. It provides physicians the opportunity to share in responsibility for the disposition of cases. This administration asks increased physician participation and seeks to join with the Department

of Business Regulation, with the state legislature, and with the Board of Medical Review, in aggregating our knowledge and wisdom to provide education and assure continuity of due process.

The Rhode Island Professional Standards Review Organization (RIPSRO), under the mandate of law, has imposed on hospital trustees the responsibility to strengthen physician and administration determination to improve and control quality of care by developing a system of risk management. In any plan, insurers should not be required knowingly to impair capital. I believe they should be permitted to establish the most equitable premium levels backed by hard statistics, subject to close actuarial scrutiny by the Society, the Attorney General, and the Department of Business Regulation— which finally approves the actuarial rating and reserve factors that we must respect. Shareholders and policy holders of insurance companies rightly expect appropriate consideration of their interests by legislators, just as much as doctors want protection. Under the pressure of the widespread publicity being given to malpractice cases these days, all doctors risk inefficiency and ineffectiveness, and anything that can be done to improve this situation must and should be done.

Mark Twain said that the seven principle islands that make up Bermuda look "like a fish hook, only smaller". Comprising in total something under 21 square miles, Bermuda today welcomes as many visitors with briefcases as with golf clubs, tennis rackets and swimming gear. This has fueled the rapid growth of the insurance industry in Bermuda. Bermuda and the Cayman Islands have become the home of captive insurance companies formed to provide special insurance services for their parent companies. Today these companies write only about 5 per cent of the premium volume written by domestic United States companies. The day may not be far off when Bermuda insurance companies will be writing 30 to 40 per cent of the total commercial and industrial insurance in the United States. Properly set up, a Bermuda insurer will pay no United States federal income or capital gains taxes until earnings are brought back into the United States, and there are no applicable income or capital gains taxes in Bermuda. Importantly, premiums of such off-shore insurers are not subject to the penalties of fair plans, JUAs, assigned risk plans, and guarantee plans—all of which are a considerable burden in the United States domestic market.

A Bermuda insurance company is easily formed if the sponsors pass the scrutiny of a government advisory committee. Legal and accounting fees to form such a company are generally under $5,000 with plenty of qualified lawyers and accountants available in Bermuda. A stock company must have minimum capital reserves of $120,000 (a mutual company $250,000) on which there is a modest duty of .25 per cent. To move from decision to form a company to organization of the company can take as little as 30 days. If there is a marketing plan to make use of the vehicle, formation of a Bermuda company makes sense. It opens the door for the insurer to the United States excess and surplus line market. One thing is almost certain. By the end of 1980 the little city of Hamilton will be known for having over one thousand insurance companies.

The Rhode Island Medical Society entered into the 1979 Rhode Island legislature an opposed bill chartering the Medical Mutual Insurance Company of Rhode Island. The general Laws of Rhode Island require of mutual companies minimum assets of one million dollars in excess of liability. This administration believes that physicians should study all options open to them pertaining to liability insurance.

Hospitals and physicians in some states, seeking to avoid the crunch of increasing malpractice rates, have developed captive insurance companies of their own. Rhode Island Hospital is self-insured under the trust method. The Boston Group (Harvard Plan) is a captive arrangement. None of these methods will *solve* the problems of ever-increasing claims and ever-increasing awards. Other methods must be developed to respond properly to the crisis.

Physicians should enlarge and expand self-regulation through the RIPSRO, and RIPSRO should share its experiences with the state medical boards and hospital quality assurance programs. Doctors must identify substandard practitioners and limit or eliminate practice privileges of such physicians. Lawyers should develop systems for settling claims more expeditiously and at less cost. For their part, insurance regulators must develop fair and accurate data collection mechanisms. Properly collected data would result in more cost-effective insurance, with rates which would reflect both the lifestyle and the malpractice experience of the individual physician. Based on inadequate and unsupported data, and using nationwide experience the JUA of Rhode Island continues to ask for increased malpractice rates. Finally, we ask that the Rhode Island JUA, after five years experience, begin to tailor its program according to the pattern of local experience and fit it to the needs of the Rhode Island community of practitioners.

Peter L. Mathieu, Jr., MD
President ■

EDITORIALS

A New Sonic Scanner

A new abdominal scanner with improvements over currently available equipment was recently introduced at a meeting of The American Institute of Ultrasound in Medicine. Designated the SKI 200 Multi-Focus Abdominal Scanner,* the new equipment yields an image of very high resolution, giving a clearer view of the target organ than is possible with currently available scanners. It also offers clarity and uniformity of focus at all depths of the scan.

The problem in ultrasonic scanning of getting sharp focus at different depths is similar to that in photography. When a camera lens at full aperture is focused on an object, other objects closer to or further from the image become blurred. If it were possible to use many cameras to take a single photograph, and each camera could focus on a different distance, the result would be a picture in which all objects are clear, regardless of their distance.

This is a principle underlying the clarity at different depths attained with the SKI 200. In lieu of cameras the scanner uses a configuration of transducers arranged in concentric rings. The transducers send sound signals to different depths, and in turn receive the echoes from these depths. This information is translated into an image that appears on a screen to give a more precise and highly focused view of the organ under examination.

In addition to producing images that are in focus in its field of view, the new scanner also produces the images in real-time. They are produced instantaneously, allowing the ultrasonographer to observe motion. As a result, examination time is reduced, and more patients can be processed in a given time.

This equipment permits scanning of any organ of the abdomen. As a general purpose diagnostic instrument, it can be used in examining the kidney, liver, pancreas, and other abdominal organs. It can be used in obstetrics to evaluate the condition and position of the fetus and to determine whether there is more than one fetus in the uterus.

An optional small parts scanner, a hand-held attachment slightly larger than a flashlight, is also available for examination of objects close to the surface of the body. The attachment is said to be useful in determining the risk of stroke by visualizing the blood supply to the brain. With this attachment, the same equipment has the capability of both abdominal and small parts scanning.

This is but another in the continuing parade of technological advances in diagnostic equipment.

Seebert J. Goldowsky, MD

* Produced by SmithKline Instruments, Inc.

Recommendations of the National Commission on Social Security

The National Commission on Social Security was created by Congress in 1977 and held hearings about the country in 1978 and 1979. Its findings are of interest to the medical profession. In an earlier decision it recommended that the Medicare provider nomination process, by which providers (hospitals) nominate their preferred carrier, be retained and that claims for Parts A and B of Medicare be processed separately to encourage plans to combine Parts A and B. It recently at a September meeting reaffirmed these decisions. Both systems have worked well, and support for the continuation of effective procedures is welcome. In addition, the Commission will propose that the programs be placed under the jurisdiction of a three-man board with a view to assuring continued

quality of services to Medicare and Medicaid recipients.

Its original recommendations regarding the Medicare contracting process were made at a July meeting. Because they are incompatible with a present Health Care Financing Administration (HCFA) policy, HCFA had asked that they be reconsidered. The Commission reaffirmed its earlier decisions and also recommended the establishment of the board similar to the old Social Security Board, with the intent of making Medicare and Medicaid policy decisions less political.

The Commission also voted to recommend that physicians should be required to elect on an annual basis whether or not to accept assignment for the year for all of their Medicare patients and that fee schedules for Medicare payments to doctors not be used. This is a mixed bag, but on the whole appears to be a reasonable compromise on fees. This decision was also reaffirmed.

Further, the Commission recommended a $1500 annual cap on Medicare beneficiaries' copayments and deductibles to counteract the damaging effect of inflation on Medicare coverage. It also recommended that reimbursement of Medicare contractors (hospitals) be on other than a cost basis, which is considered inflationary.

Other recommendations included a proposal to establish minimum standards for Medicaid, meaning minimum eligibility standards and not a federalized Medicaid program, another long overdue reform.

The Commission also strenghtened its position on long-term care. Although it made no specific recommendations, it adopted a statement of principle calling for a separate long-term care program for the aged and chronically ill financed through Social Security trust funds. This too is a long overdue program, one of the largest unmet needs in the community.

The decision to call for the establishment of a Medicare-Medicaid board was a response to concerns that Medicare beneficiaries have not been adequately served since the program was moved from Social Security into HHS, a change characterized by a heightened concern about fiscal matters as contrasted to human needs. On the whole these recommendations are practical, constructive, reasonable, and humane and should be supported.

Seebert J. Goldowsky, MD ■

COVER

From the incunabulum "Hortus Sanitatis", the woodcut shows a man resorting to the tears of a deer, a remedy whose utility has long since been forgotten. They were thought of as an aphrodisiac.

LETTERS

Better Not in Print

To the Editor:

Democracy has been defined as not just freedom, but as freedom with responsibility. Hence one is not free to shout "Fire!" in a crowded auditorium. A recent article in the *Providence Evening Bulletin* about the Emma Pendleton Bradley Hospital and its growing pains was not only done in poor taste, but illustrated a breech in confidentiality and the use of freedom without responsibility. It was good to read laudable things about Dr. Maurice Laufer and Bradley (though, as Dr. Sarah Saklad pointed out in her letter, Bradley was unique and well-known before Dr. Laufer appeared). It was irresponsible to publicize his untimely death, the staff's problems in handling its grief, and especially hanging out the dirty linen of re-organization. The press once had a code to "print all the news that is fit to print". The defining of "fit" calls for good taste, responsibility, and trust in decision-making. It seems easier to "let it all hang out" (as if to say, "See how frank, open, honest and trustworthy we are!") and damn the consequences.

Dr. Laufer would have been shocked that the staff didn't handle its own problems of loss, separation, re-organization and change within its own family — as did Mr. Burnett. I hope we do not lose the good solid man that Dr. Raymond W. Waggoner, Jr. is.

Joseph M. Zucker, MD

Anachronistic? Yes *and* No

To the Editor:

I am writing in regard to the editorial titled "Is the Rhode Island Medical Society Anachronistic?" by Dr. Charles E. Millard published in the October 1980 issue of the *Rhode Island Medical Journal.* I recognize the theme as exhorting the Rhode Island Medical Society to be flexible in its purposes and actions in meeting the changing social and economic trends of today.

Dr. Millard's point that the Medical Society could be reorganized so that other health providers and consumers in the state could have representatives in the House of Delegates is interesting. However, while the intent is laudible, I have profound reservations about it.

The Medical Society exists for medically trained individuals acting in a common bond of medicine not only for the good of society, but also to maintain its individuality and integrity separate from other professional societies. It should remain an equal among equals. Equality would be diluted by having people from all walks of life have a say in the Society's deliberations, resolutions, and actions.

However, I recognize that the reason for a medical society to exist rests upon its ability to treat all humanity; for obviously, without people to treat, there would be no need of physicians. The idea of appropriating or absorbing changing values and objectives, staying abreast of the times, could well be accomplished by establishing an advisory council consisting of representatives from allied health providers and consumers. This could indeed involve even representatives from the local press as well as from the state legislature involved in matters of health and human services. Such an advisory council could be privy to all meetings of the Medical Society including subcommittee meetings. Their viewpoints would be solicited, but they would have no voting privileges. As I would not profess to know

enough about pharmacy problems, public health problems, podiatry problems, or Blue Cross/Blue Shield problems to be a voting member of their organizations, neither would I expect representatives from such groups to have adequate backgrounds in medical matters to vote in a medical organization.

In no way do I feel that the Rhode Island Medical Society is threatened with dissolution because of indifference, lack of initiative, or inertia. Yet, the Society's momentum and prestige could well be enhanced by the participation of representatives from other walks of life. I applaud Dr. Millard's plea for fresh ideas to stimulate further progress and to help make the Society responsive to the needs of the community.

Paul T. Welch, MD, FACS

■

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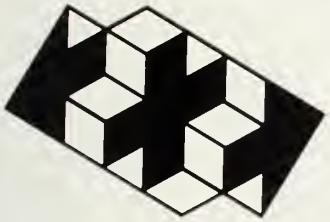

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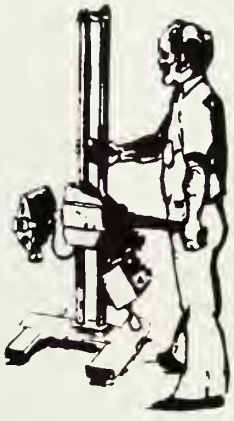

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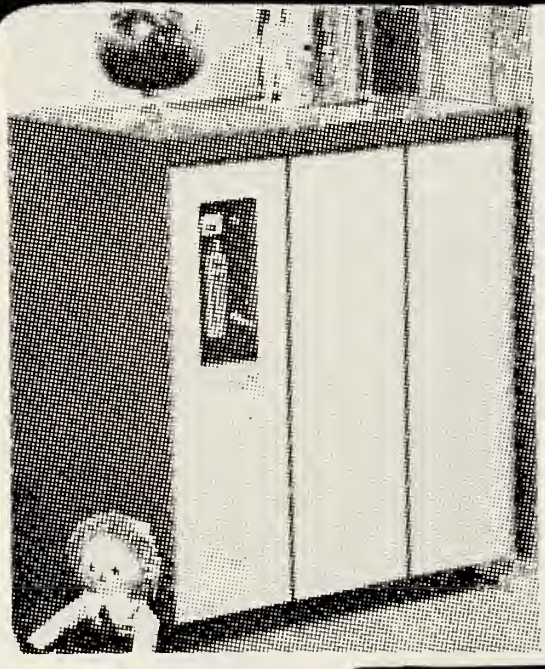

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Increasing the Yield of Primary Care-Oriented Practitioners from Residency Programs in Internal Medicine

A Marked Enrichment of the Ambulatory Experience and a Commitment to Primary Care Are Essential

Steven A. Wartman, MD, PhD
John P. Fulton, PhD
Albert F. Wessen, PhD

The present shortage of primary-care-oriented practitioners in the United States is attributable in part to a strong tendency toward subspecialization among internists.[1-3] A recent study by Wechsler, Dorsey, and Bovey,[4] for example, demonstrated that of 394 ex-residents in internal medicine in Massachusetts between 1967 and 1972 only 28 per cent were "devoting more than half their practice to a primary care subspecialty" in 1976. Relman points out that a major change in internal medicine training is needed to help resolve the primary care problem.[2]

The Problem

University-affiliated hospitals traditionally have not provided the optimal setting for encouraging the training of primary care-oriented practitioners. The reasons for this are: (1) the time spent by residents in the ambulatory setting is minimal, (2) the nature of care offered in these settings is often suboptimal, (3) the exposure of these residents to primary care-oriented physicians as role models is minimal, and (4) the focus of interest in training is upon subspecialty problems.

In most traditional residency training programs, 10 per cent or less of the time spent over the 3-year training period is devoted to ambulatory general medicine. Such minimal exposure is not conducive either to the development of confidence in treating the ambulatory patient or to the desire to pursue general internal medicine as a career. Seeing ambulatory patients one-half day per week tends to contribute to a rather diffuse experience. These patients present a potpourri of problems — many of which the resident may not be familiar with — in regard to diagnosis and treatment. In addition, the resident tends not to know these patients well, thus further increasing the problems of patient management. Continuity of patient care under such circumstances is almost unattainable.

Because the ambulatory experience is often not defined as an essential component of the medicine curriculum by those in authority, while the in-patient experience is both demanding and rigorous, residents tend to treat this small amount of ambulatory time as an extra-curricular activity of low priority. As a result, features of the ambulatory experience include: slow learning of ambulatory medicine, frustration with scheduling, truncated communication with patients, and the

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limited development of a good "feel" for the provision of ambulatory care on a daily basis (as is essential in the case of routine office practice).

The hospitalized patient's problem has already been generally identified at the time of admission, and he or she is usually acutely ill. An out-patient's problem, however, may be vague, masked, and less acute, and may require more time for proper diagnosis and treatment. In dealing with the hospitalized patient, the resident is able to carry out a comprehensive and intensive medical work-up quickly. In the ambulatory setting, the patient is under the physician's control to a far less extent. Nevertheless, because of the predominant, hospital-based orientation of most residents, ambulatory patients tend to be approached in the same disease-oriented manner as in-patients. This frequently results in a desire on the part of the resident to solve all the patient's problems on the first visit. Typically, this can lead to the over-utilization of laboratory tests, over-treatment of the patient's condition, and an unsatisfactory working relationship with the patient.

In most traditional residency training programs, the ambulatory setting has been a medical clinic in which the care provided is suboptimal. Because many of these medical clinics have roots in traditional charity care, their patients characteristically tend to assume a low status. This provides a setting for the rendering of care for which neither the provider nor the patient has particularly high expectations and in which communication problems tend to be maximized. Learning in this setting is given a low priority and becomes a chore.

Additionally, the exposure of medical residents to primary-care-oriented internist role models is minimal in most settings. While residents have ample time to consult with subspecialist physicians on the in-patient service, there is rarely time to consult with general internists in either in-patient or ambulatory settings. Furthermore, generalists often hold lower status than subspecialists as the latter frequently perform dramatic procedures and offer "definitive" consultations. Medical residents, who throughout their education have striven for academic excellence, easily emulate subspecialists as academic role models. However, the general internists they see, either as private physicians, ward attendings, or clinic physicians, are less likely to have the status of full-time faculty and may be less impressive in their knowledge of current medical literature. Accordingly, they may appear to be less desirable role models from an academic perspective. As a result, the pervasive role model of the subspecialist predominates in residency training.

Lastly, the subspecialty focus of residency training can be viewed from the perspective of the organization of medical education. Departments of Internal Medicine have been organized into clearly defined subspecialty divisions, each with its own faculty, teaching, and research efforts. Furthermore, there are well-developed, internal medicine subspecialty board examinations which are viewed as an additional knowledge step beyond the general certification given by the American Board of Internal Medicine. The general internists have not held a clear-cut place in academic departments of internal medicine; nor have such individuals' teaching, clinical and research expertise been well defined. Thus, the educational thrusts within departments of internal medicine have traditionally been upon subspecialty problems.

The Solution

The successful development of a primary-care-oriented internal medicine residency training program requires the fulfillment of four criteria: (1) increased time spent by residents in the ambulatory setting, (2) marked enrichment of the ambulatory experience, (3) increased exposure to primary-care-oriented general internist role models, and (4) commitment to primary care as a principal goal of the general internist.

A solid experience in in-patient medicine remains essential for the training of all internists. Hence, changes made in the curriculum to increase time spent in the ambulatory setting must not compromise this experience.* In-patient rotations must be reduced, but only enough to accomplish two objectives: (1) to begin the regular practice of ambulatory medicine in the first year of the residency program with increasing amounts of time devoted to it in ensuing years, and, (2) to generate a two- to three-month block period in each year when the resident is given an intensive experience in ambulatory medicine. The resident can still spend nearly 50 per cent of his/her time in in-patient medicine and have the opportunity to take four to six subspecialty electives during the 3-year training period.

The ambulatory practice must stress continuity and commitment to patients. Emphasis should be placed on actually building a practice among a panel of patients who identify with the resident as

*With good residents, however, this reduction can be substantial without discernible effects on tested clinical competence.[5]

their primary provider. The practice is established in the first postgraduate year and is located in a personal and intimate setting which promotes the development of a long-term, caring doctor-patient relationship. The ambulatory block allows residents to build a practice before they begin their second year, thus enhancing continuity of care. In addition, the block experience simulates the *pace* of a professional office practice. It also allows the resident to focus undivided attention on ambulatory care, without the dominance of the in-patient experience.

The enrichment of the ambulatory experience is based upon the establishment of a cadre of professionals dedicated to improving ambulatory care. The cadre must be interdisciplinary because primary-care-oriented medicine cuts across a variety of disciplines including medicine, psychiatry, and the social sciences. While it is essential for the core faculty to develop a strong commitment to patient care, they must also have an academic focus to stimulate critical thinking about ambulatory care. Input from both behavioral and social scientists can take place during in-patient rounds, out-patient case conferences, and formal didactic seminars. Establishment of a Division of General Internal Medicine within the Department of Medicine serves to provide the organizational and administrative integrity necessary to support such faculty in academic medicine.[6]

Furthermore, the faculty must support the involvement of professionals who have traditionally had a relatively low status in the medical care system. Nurses, nurse practitioners, social workers, and others make critical contributions to the quality of care in the ambulatory setting. They must become a central part of creative change in primary care medical practice. Health professionals must work together as an organized team with the focus on the delivery of high-quality patient care. In order for team members to contribute significantly to patient care, the importance of group communication, support, and confidence must be stressed.

In addition to the above, health services research and quality assessment efforts must be developed which have broad scope but very practical aims. These efforts can bring problems into focus, stimulate questions as well as research, and bring about improvements in the delivery of care. Residents should be aware of these efforts and be encouraged to participate whenever possible.

Another feature of the primary care residency program involves a markedly increased exposure of residents to the role model of the primary-care-oriented physician. These physicians must be true generalists; that is, they must be confident in managing and discussing many topics in internal medicine, must be able to take care of patients both in in-patient and ambulatory settings, and must be able to function as internal medicine consultants. They must also be accomplished in integrating the biomedical, psychological, and socio-environmental aspects of their patients' care. Such faculty role models, besides being involved in direct patient care, should hold some responsibility for the quality of patient care rendered by the residents they supervise. They must also have some expertise in critically evaluating ambulatory illnesses and their management.

Unlike the in-patient setting, in which care, procedures, and charts are more visible to the professional community, the ambulatory setting does not allow residents easily to observe others delivering care. Thus, the manner in which the general internist functions as consultant and supervisor, and interacts with the patients of other physicians, becomes critical to his or her effectiveness as a role model.

The faculty general internist should be encouraged to see residents' patients, check physical findings, and interview patients in order that the residents may observe how the internist conducts himself or herself with patients. (Of course, the role model must be careful not to take over or undermine the role of the resident in the care of the patient.)

Lastly, there is the need for commitment to the practice of primary-care-oriented medicine as the principal goal of the general internist. Emphasis must be placed on the *whole* patient, including the psycho-social dimension of care. The development of long-term, caring relationships with patients in a setting that stresses continuity of care must be paramount.

In sum, the development of a successful primary care internal medicine residency training program in a university hospital must involve four key features: (1) increased time spent in the ambulatory setting for residents, (2) enrichment of the ambulatory experience, (3) increased exposure to the role model of the primary care-oriented physician, and (4) commitment to primary care as a principal goal of the general internist. These steps provide the basis for a training program that is practical and comprehensive, yet does not dilute significantly those traditional components of internal medicine training which contribute to the de-

velopment of a solid foundation for the practice of general internal medicine.

Summary

University-affiliated hospitals have not traditionally provided optimal settings for encouraging the training of primary-care-oriented practitioners. The reasons for this include: the small amount of time spent and the nature of care offered by residents in these settings, the minimal exposure of residents to appropriate faculty role models, and the focus of interest in training upon subspecialty problems.

The successful development of a primary-care-oriented internal medicine residency training program must address these issues, and, in addition, requires a marked enrichment of the ambulatory experience and commitment to primary care as a principal goal of the general internist.

While these steps provide the basis for a training program that is practical and comprehensive, care must be taken to insure that they do not dilute the rest of the internal medicine training experience.

References

[1]Perkoff T: General internal medicine, family practice or something better? N Engl J Med 299:654-657, 21 Sep 78.

[2]Relman S: Who will train all those primary care physicians? N Engl J Med 299:652-653, 21 Sep 78.

[3]Wessen A: On the demand for graduate medical education positions by specialty, in Kilpatrick K E (ed): Policy Analysis for Physician Manpower Planning. U S Department of Health, Education and Welfare, 1977.

[4]Wechsler H, Dorsey J L, Bovey J D: A follow-up study of residents in internal medicine, pediatrics, and obstetrics-gynecology training programs in Massachusetts. N Engl J Med 298:15-21, 5 Jan 78.

[5]Goroll A H, Stoeckle J D, Leaf A: Inpatient performance of primary care residents: impact of reduction of time on the ward. J Med Educ 54:392-395, May 79.

[6]Bynny R L, Siegler M, Tarlov A R: Development of an academic section of general internal medicine. Am J Med 63:493-498, Oct 77.

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Dental Radiography — A Social Scientist's Perspective

Study Indicates Need for Better Performance in Preventing Over-Exposure to X-Ray in Dental Offices

James B. Gamelin

This paper is a discussion and analysis of a study of 50 dental facility supervisors who were rated on seven criteria of radiation safety and protection. The purpose of the study was twofold: to observe any trends among the state's dentists in their attitudes and use of x-radiation and to improve the inspection techniques used by the Radiation Control Agency for dental facilities in respect of the administrative requirements of its registrants.

In June 1978, the Radiaton Control Agency of the Rhode Island Department of Health initiated a registration and comprehensive inspection program of all x-ray facilities in the state. There are presently 786 registered x-ray facilities in the state, of which 434 are intra-oral dental facilities. These offices comprise the single largest group of registrants, 55 per cent. The sample of 50 selected for this study comprises 12 per cent of all dental registrants.

The inspection of dental facilities, as well as of all other categories, commenced in December of 1978. All facilities selected for inspection are chosen on a random basis, using the specified numbers assigned to the registrants. Therefore, the sites for inspection are geographically distributed throughout the state, with all facilities at equal risk for inspection.

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Study Method

From the onset of the inspection program in December 1978 to 1 July 1979, 100 dental offices were chosen and inspected. The 50 facilities chosen for this study were those inspected by the author from March to July 1979.

Each facility is inspected for both equipment and administrative compliance with the state regulations. For all dental offices the facility supervisor is also the dentist, and he is interviewed in order to determine the degree of compliance for his facility. The doctor's technique of taking a radiograph is observed, and his film processing technique is also witnessed in relation to the equipment surveys. The administrative compliance is measured by study of written safety procedures provided to employees, the instruction to employees on radiation protection, records of personnel monitoring (if any), and other information and maintenance records.

For this study seven categories were rated based not only on regulatory compliance, but also on the attitudes and understanding of the dentists on dental x-ray use. Each of the seven categories was rated "excellent", "good", "fair", and "poor". An "excellent" rating received 3 points, "good" 2 points, "fair" 1 point, and "poor" zero points. The points were tabulated for each of the seven categories and were applied to the supervisor's evaluation with the maximum possible score being 21 and the lowest zero.

In order to obtain the highest possible level of accuracy, supervisors were rated as objectively as

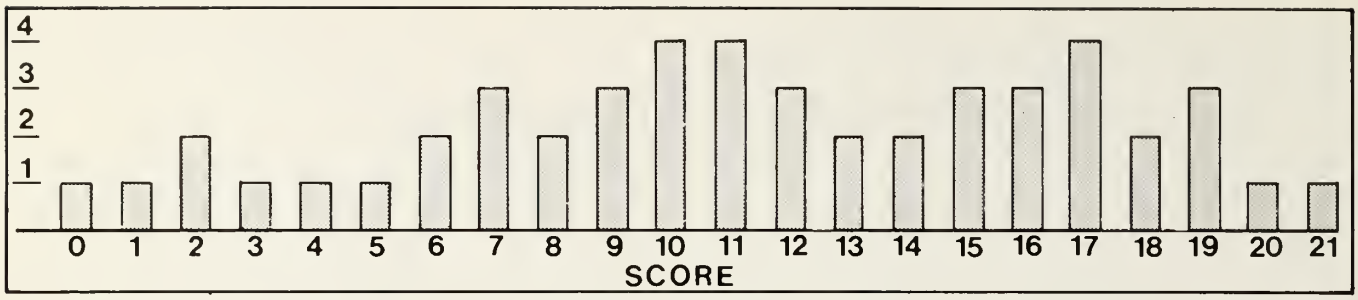

Figure 1. Results of evaluation of dentists' attitudes and understanding of dental x-ray use, showing number of dentists obtaining scores from zero to 21.

possible with minimum consideration given to the supervisor's personality. This was achieved by scoring the evaluations 24 hours after the inspection when any immediate personality impressions would have been considerably dissipated. No more than one evaluation was carried out each day, and all evaluation sheets were immediately filed. No analysis was completed until all 50 scores had been obtained. Further to assure the objectivity of scoring, each category was assigned specific criteria for judgement and rating. The criteria used for the four grades in each category may be obtained by communicating with the author. The seven categories were as follows: category 1 — interest and understanding of regulations, category 2 — cooperation in inspection, category 3 — understanding of equipment technique procedure, category 4 — understanding of film processing, category 5 — interest in patient exposure, category 6 — interest in safety procedures for facility employees, and category 7 — overall inspector's impression.

After the 50 supervisors were scored, the following additional items were obtained from the inspection reports and were included in the study: number of x-ray units at the facility, number of employees, weekly workload of films taken, and number of administrative deficiencies and equipment violations cited for the facility. All of these items were factual. Since they were included after the scoring, they had no influence on the objectivity. The dentist's date of birth, college of graduation, and date of graduation, were obtained from the Division of Professional Regulation in order to reveal any significance of the scores to trends among the dental community.

Results

At least one dentist was found in each score from zero to 21 (Fig 1). The frequency of scores displays a skew to the higher end. The mean of the group is 12.16 with a standard deviation of 5.6. The median was also 12. No more than four dentists are found for each score.

Those who scored between zero and 5 were considered to be "poor", those between 6 and 10 "fair", those from 11 to 15 "good", and those from 16 to 21 "excellent".

Most dentists had overall scores in the "good" range. It was encouraging to find that only 7 dentists had ratings of "poor" overall. Figure 2 provides a closer view of the strengths and weaknesses. It shows a breakdown of the seven categories with the number of dentists found in each rating group.

Although most dentists scored favorably in the first category, 46 per cent had a negative attitude toward the regulations or felt that they were not worthwhile. Further study showed that 5 of these 11 in the "poor" category also had similar ratings in the other 6 scores. Only 3 of the 11 with an "excellent" score received overall scores of 14 or below.

A clear majority of those inspected were cooperative during the inspection. Only 6 dentists did not permit sufficient time for a proper administrative interview. They had failed to allow specified time for the inspection, although all inspections are arranged by phone and a notice of inspection is issued 4 weeks in advance of the inspection. A further analysis revealed that those facilities inspected last were rated at least "good". A probable explanation is that dentists have learned what to expect in terms of the inspection process through discussion with their colleagues who were previously inspected.

The third category on technique procedure revealed the lowest frequency of scores in the "excellent" range. Most dentists did not have an extensive knowledge of radiographic procedures. It was found that 5 of the 7 dentists rated as "excel-

lent" had graduated from Tufts University, and all five graduated after 1965. Twenty-four dentists, or 48 per cent, rated "good" in this category. All had been visited by the agency before and had participated in a thermoluminescent dosimetry (TLD) study in 1973. Their previous files also revealed that all 24 had received technique normalizations in the past and were continuing to follow those normalizations. Of those 19 rated as "fair" or "poor", 10 dentists failed to demonstrate a knowledge of kilovoltage and milliamperes. They simply knew the mechanics of obtaining a radiograph, but improper cone tip placement was found in several. All 10 dentists had also received previous technique normalizations but were not following those normalizations.

In the category of film processing, 42 per cent of the dentists surveyed had no better than a fair rating. In conducting this survey, a distinct pattern was noticed between technique of taking an x-ray and film processing. Those dentists receiving a "fair" or "poor" rating failed to understand that good technique of film processing was as important as good technique of taking x-rays. They failed to demonstrate adequate knowledge of time/temperature developing, and those with a "poor" rating were also using sight development of films. It was significant that of the 9 dentists with an "excellent" rating 4 were using an automatic film processor and demonstrated a genuine interest in its operation. Many of the 14 dentists rated as "good" had assistants develop all films; however, they were aware of the techniques that were followed.

In the fifth section, "interest in patient exposure", more dentists were rated as "fair" than were given any other score. Only 18 per cent were considered to have an "excellent" interest in using the least exposure possible. Of these 9 with the highest score, 3 dentists were using techniques below the dental exposure normalization technique (DENT) standard, but were willing to sacrifice some film contrast in order to reduce patient exposure. All 3 were also found to have automatic film processors, and they felt that the use of such processors enabled them to use lower exposures. Those who did receive a "good" rating were aware of the need to

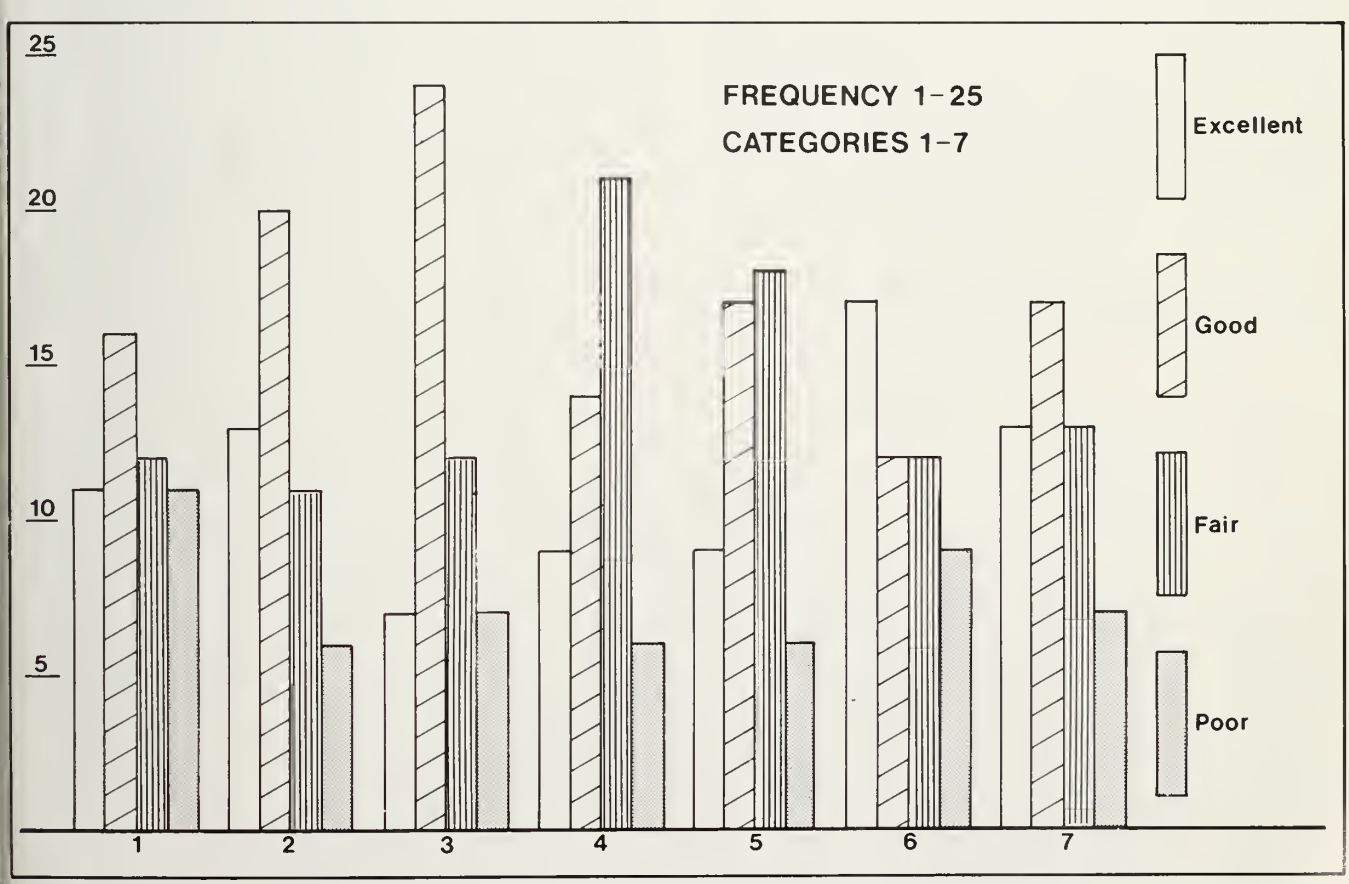

Figure 2. Frequency of dental x-ray evaluation scores in seven categories: 1 - Understanding of regulations; 2 - Cooperation with inspection; 3 - Equipment technique; 4 - Film processing technique; 5 - Interest in patient exposure safety; 6 - Interest in safety for employees; 7 - Overall inspector's impression.

reduce patient exposure but did not necessarily use the lowest exposure. They were following technique normalizations previously given by the agency. Of the 18 "fair" scores it was found that half were a result of the use of faulty mechanical timers, which resulted in unnecessary patient overexposure. The other half in this rating had disregarded previous technique normalizations by the agency and preferred to use a higher exposure technique. This same group had also received low scores for the four previous ratings. All 6 dentists with a "poor" score were found to be using a cone tip exposure in excess of 1 roentgen. These 6 had also received "poor" scores on film processing.

The sixth category of "safety procedures for facility employees" had the highest number of "excellent" scores. Of the 17 instances of "excellent" scores, personnel monitoring was used in 10. In all 17 facilities at least one hygienist was employed, and no untrained employees were used. Also, in nearly half of these 17 offices the supervisor explained that radiation protection is a common subject for discussion in office meetings. Of the 12 receiving "good" ratings, 5 were also using personnel monitoring, but improper use of control badges or poor maintenance of badge records was found. The other 12 offices with a "fair" score had no safety procedures, although the employees had received basic instruction on radiation protection. There was a higher prevalence of noncertified dental assistants and untrained employees in these twelve offices. The 9 offices with a "poor" score were found to be using unprotected operator positions for taking x-ray films. Employees had no basic instruction in radiation hazards or protection.

Concerning the final category of "overall impression", it was found that 60 per cent of the dentists surveyed had a "good" or "excellent" score. Fifteen of the 17 dentists rated as "good" had similar scores for the 6 previous items. All 13 supervisors rated as "excellent" had at least "good" scores for the other items, and they all demonstrated a positive and cooperative attitude. The remaining 40 per cent had some significant problems with their radiation safety program. The problems involved failure on the part of the dentist to demonstrate any genuine concern either in terms of employee safety or patient exposure.

Analysis of the data revealed several trends. Those dentists who were generally cooperative had overall scores above the 12.16 mean. Those who failed to take any interest in the regulations accounted for 68 per cent of those with a final score below the median level. Virtually all dentists who received "excellent" scores in technique procedure also received such ratings in film processing and interest in patient exposure. All six dentists who received "poor" scores in patient exposure also received a "poor" score in safety

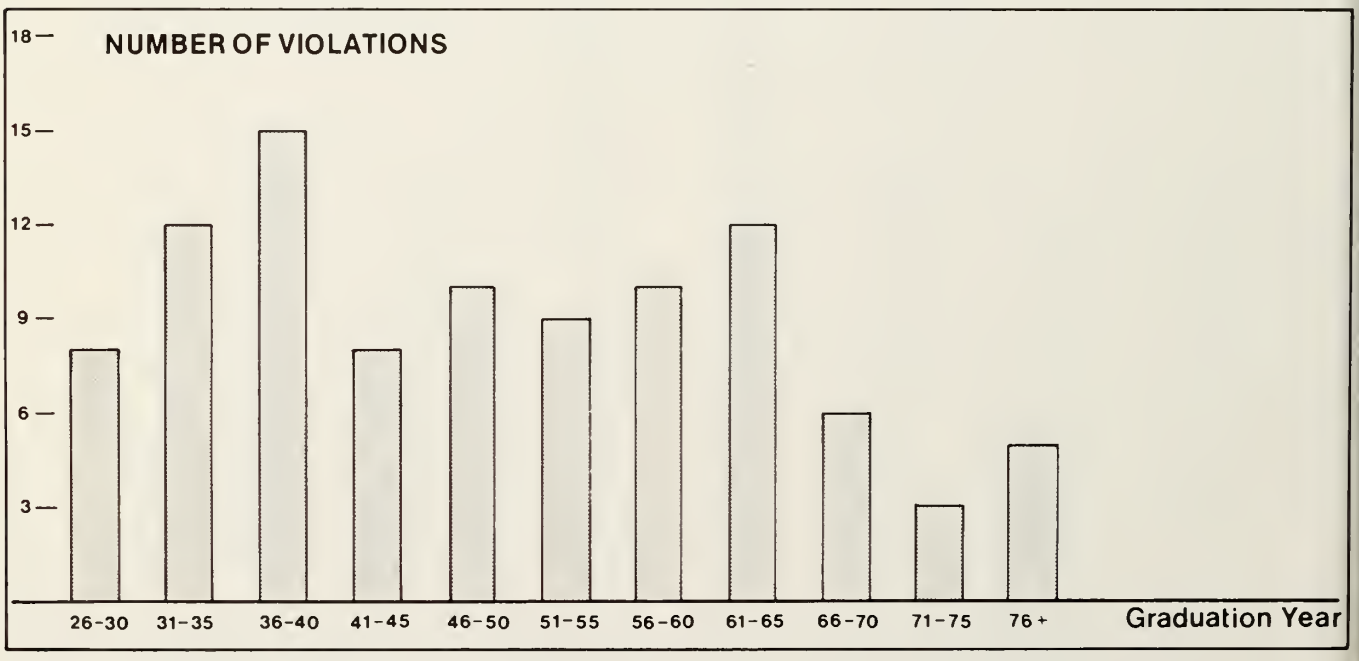

Figure 3. Number of violations of technique procedures recommended by the Radiation Control Agency by dentists graduating 1926-30 to 1976+.

procedures. It was also noted that most dentists remained consistent throughout the seven categories. Only 6 dentists had scores of "excellent" in some categories and "poor" in others.

In conducting the inspections, it was discovered that many dentists were interested in the success or failure of their comrades in terms of the regulatory process. Younger dentists had the impression that they had fewer problems than older dentists, since they had been more recently trained. They also felt that inspections should be concentrated on those older practitioners, since the probability of equipment and technique violations would exist there. Older dentists on the other hand felt that because of their experience they did not require such regulations. They believed that younger dentists should be regulated, since their behavior could be modified before bad habits were formed.

A breakdown of the 50 surveyed dentists with their dates of graduation and scores was conducted to determine any trends among age groups. Twenty-six per cent of the groups have graduated since 1970. These supervisors scored well in the category of technique procedures and film processing. Most of the young dentists had administrative deficiencies, but only 2 were cited for major violations.

In contrast, an analysis of an equal number of dentists who graduated between 1946 and 1955 revealed that 8 dentists were rated as "fair" or "poor" in the area on technique procedures. These 8 dentists were ignoring previous technique normalizations provided by the Radiation Control Agency. The category "interest in patient exposure" also found five dentists with scores of "fair" or "poor".

Indeed, as shown in Figure 3, those who graduated after 1971 were cited for an average of only 2.4 violations or deficiencies. Those who graduated prior to 1960 received an average of 6.2 violations as compared to 4.3 violations for those graduating after 1961. Dividing the sample into graduation dates at the median level of 1960, there are significant differences as between the "poor" and "excellent" scores (Fig 4). There is a strong correlation between scores and the number of employees. The calculated correlation coefficient here was found to be .24188, significant at the 95 per cent confidence level. Those with lower scores tend to have more employees than those with higher scores. There is also a higher incidence of untrained dental assistants as compared to certified assistants or licensed dental hygienists.

As a result of the significance correlations between scores and the number of employees, further study was carried out on the evaluation of safety procedures. Twelve supervisors were rated as "fair" in this category. The group had an average of 2 employees per facility with 10 of the 12 offices employing a non-certified assistant who had some

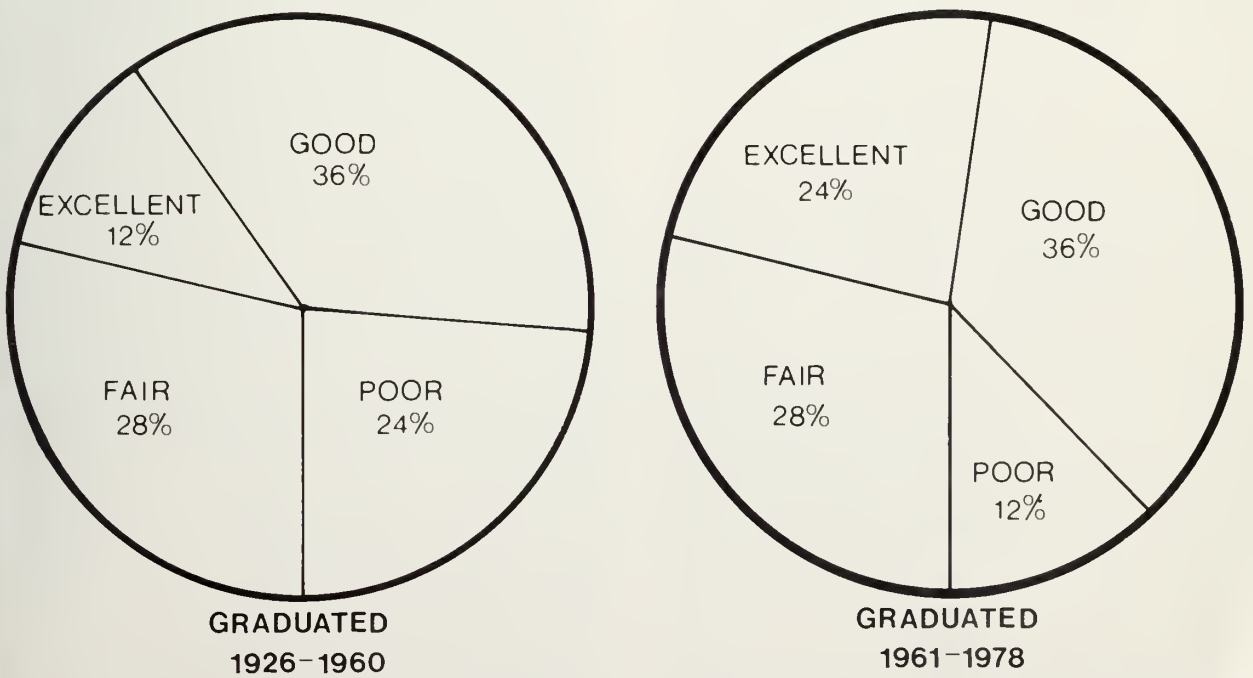

Figure 4. Comparison of overall score results between dentists graduated 1926-1960 and 1961-1978.

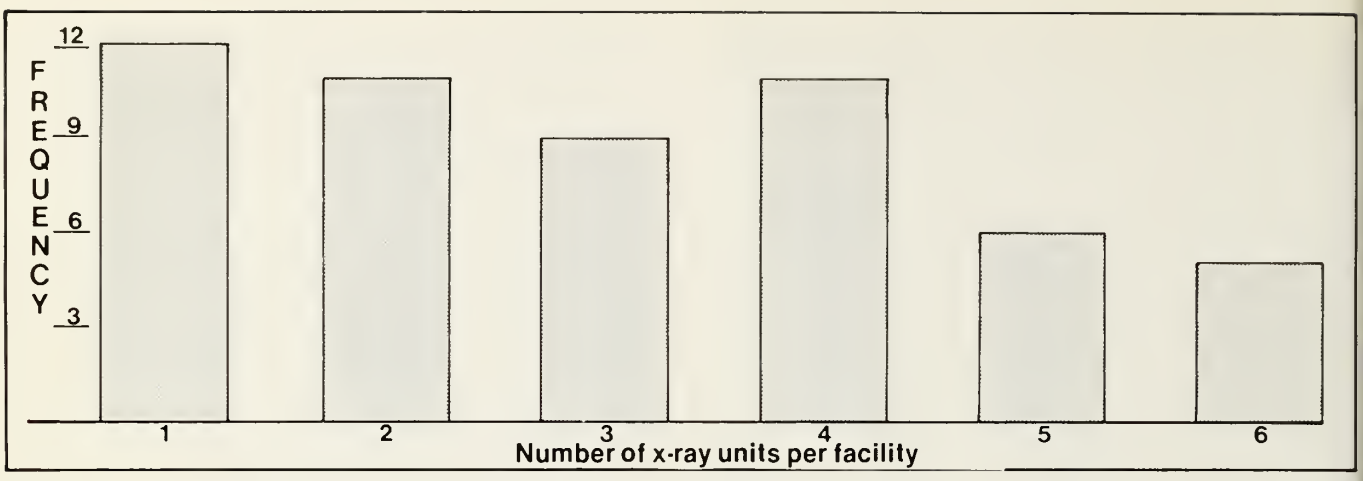

Figure 5. Frequencies of one to six (maximum) x-ray units in evaluated facilities.

involvement in taking radiographs. The employees had only minimal instruction in radiation protection. In the nine offices with a "poor" rating in safety, five had one employee; and in the other four, the dentist was the sole employee. In all 5 offices with an employee, it was found that the assistant had no formal training in radiation protection.

In terms of the number of x-ray units found in the 50 offices, the inspection reports show that the maximum number was six per facility (Fig 5).

There was a total of 147 x-ray systems located in the 50 offices with an average of 2.9 units per facility. Using the average of 3 units per facility, it was found that those facilities with 3 or more units had lower evaluation scores than those with 1 or 2 units. In fact, 11 facilities with more than 3 units had evaluation scores below the mean of 12. These offices also received a total of 64 violations, 48 of which directly related to facility equipment and patient exposure. This was an average of 2.56 violations per facility with 3 or more x-ray units and a score below the mean.

In comparison, those with scores above 12 generally had no more than two units per facility, and seven offices had only one x-ray machine. For those offices with scores above 12, there was a total of 17 violations issued for an average of 0.68 per facility. This illustrates that those facilities which have a sound and capable safety program generally have fewer units and fewer violations than those with lower scores.

In view of this fact, a study was then carried out on the evaluation scores and the number of films taken at a facility each week. Of the 25 facilities at or below the median level, an average of 76.8 films are taken each week; whereas in the remaining 25 facilities an average of 51.7 films are taken each week.

Eighteen of the 25 facilities below the median level used higher exposures than necessary for the patient, in 5 cases over 1 roentgen per exposure. These same facilities had a significantly higher workload average than those above the median level.

Conclusions

The results of the facility supervisor evaluation provides significant insights into problems that must receive attention and into the uses of dental radiography. By projecting the data from this sample, it can be assumed that 2 out of every 5 dentists take no interest in the regulations. Older graduates had more objections than recent graduates to being regulated.

Although they do not necessarily favor the regulations, most dentists are cooperative during the inspection. The advanced prior scheduling of inspections accounts for the success of this project. Certainly, cooperation is important, since further progress hinges on the relationship developed between the agency inspector and facility supervisor.

The results in the category of understanding of technique procedure reflect the past successful efforts of the Radiation Control Agency. Sixty per cent of the study group received a "good" or "excellent" score. This can probably be explained by the fact that several previous efforts by the agency dealt with equipment use. Dentists were educated

in good technique procedure through the TLD study of 1973 as well as continuing normalizations and nationwide evaluation of x-ray trends (NEXT) surveys. Many bad habits were corrected or prevented through these surveys.

Unfortunately, not many dentists understand the importance of correct film processing. Forty-two per cent of the dentists had some significant problems in this respect. Although many supervisors have delegated this responsibility to assistants, it was found that correct instructions were for the most part not given. In several cases the x-ray exposure of patients could be significantly reduced if improvements were made with darkroom procedures.

Those facilities with several units also tended to have more problems and lower scores. The dentists in larger facilities have less emphasis on safety. The employees are delegated more responsibilities, but fewer safety procedures are provided to or understood by employees.

Thus, some specific problems must be the focus of concentration in order to improve the safe use of x-rays in dental offices. These include the relationship between good darkroom techniques and patient exposure, the need for dentists to realize that the inspection process offers guidance as well as compliance, and the need for adequate training of employees.

Non-certified dental assistants have generally received little or no instruction in radiation protection. As a result, several unsafe operating practices were found, most importantly that of unprotected operator positions. It was a common misconception that use of a lead apron affords all necessary protection.

In those offices with untrained assistants, a significant effort must be continued in explaining the importance of radiation protection. Although the first initiative must be from the employer, there are situations where employees can be prompted to motivate the dentists to take a more active role in radiation safety.

In addition to employee training, a special effort is needed to instruct the dentists themselves in various aspects of radiation safety. This paper has emphasized the fact that older graduates require an updating in their perspective on radiography. This can be accomplished in several ways.

One of the easiest methods is through peer pressure and recognition. It was observed in conducting this survey that dentists are a close-knit society whose members are aware of their comrades' actions. This was demonstrated by the fact that many dentists were aware of the inspection procedure simply through telephone conversation with their associates. Many dentists were curious about the reactions and inspection success of other dentists, and certainly any information given by the agency could be of significant use. If dentists realize that their associates perceive the importance of things such as good darkroom technique, progress can be anticipated.

Many of the beliefs and practices of older dentists originated during their training. They have not been made aware of advances in radiography or in film processing. One possible solution would be the implementation of continuing education courses and seminars.

Finally, an aim of this paper was to evaluate the inspection process of the agency. The inspection process must be flexible because of the varying needs and beliefs of dentists. Younger dentists with flourishing practices require inspections that are geared toward preventing bad habits and indiscriminative use of x-rays. For older dentists, emphasis should be placed on investigations of employee training and equipment compliance. Technique procedures are also a matter of concern.

Because radiation protection involves people as well as equipment, the success or failure of a radiation safety program is largely dependent upon the facility supervisor. Equipment is only one aspect of control; this study has indicated future avenues for exploration and also shows that much work is still needed to assure that all dentists will get a perfect score.

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Lymphangiography without Blue Dyes

Case Report of an Allergic Reaction and Technique

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Lymphangiography by cannulation of pedal lymphatics channels had previously been performed at our hospital following opacification of the pedal lymphatics with a vital blue dye, as described originally by Kinworth[1,2] and performed by most radiologists. Allergic reactions to the various blue dyes have been reported in the literature, varying from local manifestations with erythema, local abscesses, and skin necrosis to generalized systemic anaphylactic reactions.[3-8]

The overall incidence of allergic reactions has been reported as from 1 to 2.5 per cent.[9,10] Currently, no blue dyes are approved for such use by the US Food and Drug Administration (FDA) Bureau of Drugs.[11]

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At the Miriam Hospital, a 275 bed general hospital, we perform approximately 15 lymphangiograms per year. We recently encountered our first patient with an allergic reaction to methylene blue dye:

Case Report

A 24 year old female with a biopsy diagnosis of Hodgkin's disease was referred for bilateral lymphangiography for staging. A solution of 1 per cent methylene blue and 1 per cent Xylocaine® was injected intracutaneously, 0.5 ml in the first and fourth interdigital webs of each foot (total approximately 2.0 ml). Within a few minutes, the patient complained of severe pain at the injection sites. Edema and erythema were present in these areas and advanced proximally with the blue dye. She was treated with epinephrine and diphenhydramine, and the examination was postponed. Approximately ten hours later, she experienced chills and fever. There was no dyspnea or other evidence of a generalized allergic reaction. Four days later, the pedal reaction had subsided completely and the blue dye was dissipated. The lymphangiogram was subsequently performed without the aid of blue dye, with no difficulty.

Discussion

Since this experience, we have performed an additional 10 bilateral lymphangiograms without the use of blue dye. In an additional patient, dye was injected after an initial unsuccessful attempt without its use. The lymphatics filled with blue dye almost immediately, with no significant loss of operating time. In spite of a relatively small

number of procedures performed by any one radiologist in our department, we have generally encountered no greater difficulties without blue dye, and in most instances the procedure has been facilitated by the lack of blue staining of adjacent tissues. This method was first described by Maddison[12] and subsequently by Sigurjonsson[13] and Yune[14], who have reported no additional operating time.

Lymphatic channels are fairly easy to distinguish from veins by their beaded irregular caliber that distends when lymph is "milked" from the toes, and by their glistening milky-white opalescence. A further useful aid is their tortuosity and inelasticity. When a lymphatic is elevated off the fascia and then released, it assumes a floppy, redundant course, differing from its original position.

Veins are distinguished from lymphatics by a central bluish-red streak; veins tend to back-fill with blood after having been milked. A further characteristic of veins is their elasticity. As opposed to a lymphatic, a vein tends to snap back to its original taut position when released.

Nerves are very elastic and have a homogeneous solid yellowish-white color.

After localizing and cleaning a lymphatic of adequate size, we cannulate the vessel by needle or catheter. Ethiodol® is injected by a lymphangiography pressure injector (Cordis) at approximately one ml every ten minutes for a volume of approximately 6 to 8 ml for each leg. The procedure is performed on a fluoroscopic table, allowing confirmation of the intra-lymphatic position of the catheter or needle under fluoroscopy without radiographs. After approximately 0.25 ml have entered the vessel, fluoroscopy of the calf will confirm the correct intralymphatic position of the contrast. If the contrast medium is within a lymphatic, the vessels will continue to divide, becoming more numerous proximally, and will appear as a continuous slowly flowing stream. If the medium is within a vein, the contrast medium will bead into rapidly flowing droplets.

Lymphangiography without the use of blue dye has several advantages: 1. No blue discoloration of the feet (with possible long-term tattooing), body or urine. 2. No risk of allergic reactions to blue dye, either localized or systemic. 3. No risk of ulceration[3] or skin slough. (A personal communication sites a patient who had sloughing of the skin on both sides of a toe necessitating a skin graft.) 4. The operator is not limited to blue streaks; some lymphatics do not pick up the blue dye. 5. Perhaps of greatest importance is the fact that there is no longer an FDA approved blue dye available commercially.

If the lymphangiogram is initially attempted without blue dye, and a lymphatic cannot be successfully identified, blue dye may then be injected during the surgical procedure and will appear almost immediately within the lymphatics. Therefore, we feel that the use of blue dye is not necessary to identify lymphatics and adds an unnecessary risk of morbidity to the study.

Since completion of this report, Kapdi *et al*[15] have confirmed this suggested technique in 510 consecutive patients.

Summary

A technique for cannulation of the superficial lymphatics of the foot without the aid of vital blue dye is described. A case of allergic reaction to methylene blue dye is reported. Since there is no FDA approved dye currently available and the described technique does not require any increased operating time, it is recommended that lymphangiography be performed without vital blue dyes.

References

[1]Kinmonth JB: Lymphangiography in clinical surgery and particularly in the treatment of lymphoedema. Ann Rev Coll Surgeons England 15:300-315, Nov 54.
[2]Kinmonth JB, Taylor GW, Harper RK: Lymphangiography, a technique for its clinical use in the lower limb. Brit Med J 1:940-942, Apr 55.
[3]Perry PM, Meinhard E: Necrotic subcutaneous abscesses following injections of methylene blue. Br J Clin Pract 28:289-291, Aug 74.
[4]Collard M, Collette JM: Les modalities cliniques de l'allergie au bleu patente violet. J Belg Radiol (Bruxelles) 50(5):407-410, 1967.
[5]Koehler PR: Complications of lymphography. Lymphology 1:116-120, Dec 68.
[6]Lau BP: Complication of lymphangiography. Arch Derm 101:702-703, Jun 70.
[7]Kopp WL: Anaphylaxis from alphazurine 2G during lymphography. JAMA 198:668-669, Nov 66.
[8]Biran S, Hochman A: Allergic reaction to patent blue during lymphangiography. Radiol Clin Biol 42(2):166-168, 1973.
[9]Sieber F: Incidents after the subcutaneous instillation of patient blue for lymphography. Med Bild 11(4): 102-103, 1968.
[10]Mortazavi SH, Burrows BD: Allergic reactions to patent blue dye in lymphangiography. Clin Radiol 22:389-390, Jul 71.
[11]American College of Radiology Bulletin. January 1977, p 12.
[12]Maddison FE: Lymphatic cannulation without dye. Radiology 88:362-363, Feb 67.
[13]Sigurjonsson K: Lymphography without the aid of vital dyes. Lymphology 7:121-123, Sep 74.
[14]Yune HY, Klatte EC, Batnitzky S: Identifying dorsal pedal lymph vessels without blue dye. Am J Roent 132:302-303, Feb 79.
[15]Kapdi CC: Lymphography without the use of vital dyes, Radiology 133:795-796, Dec 79.

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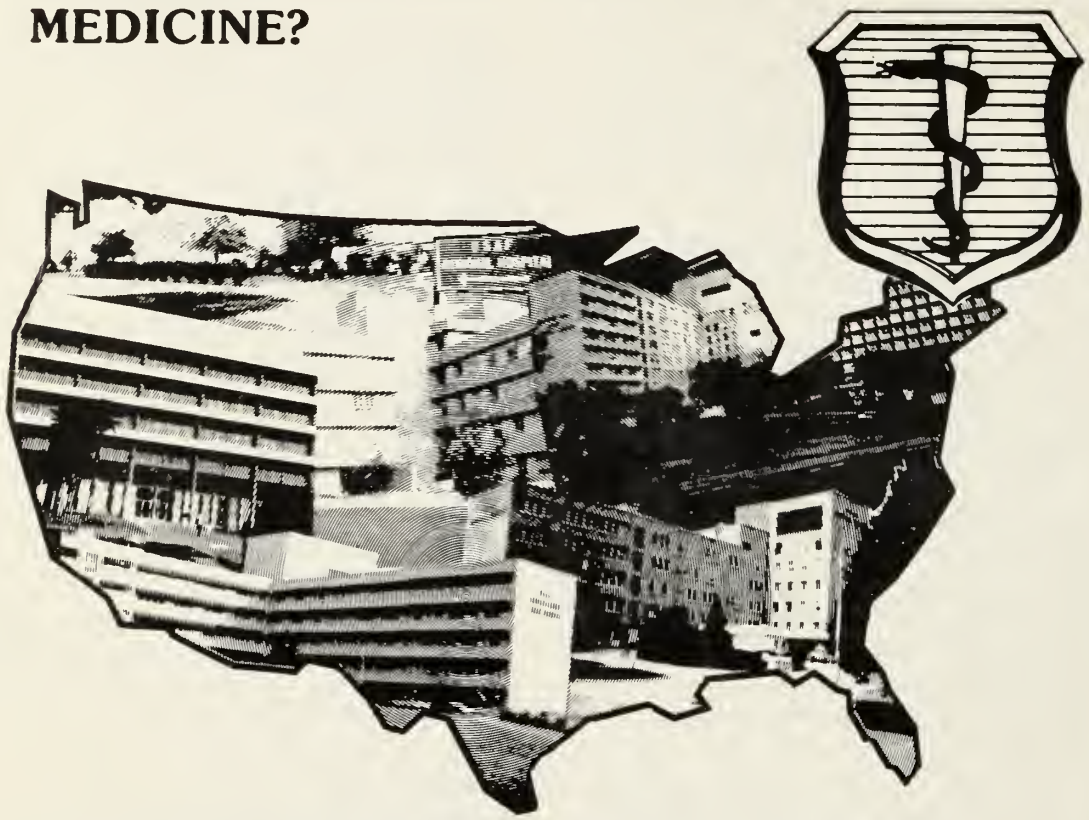

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